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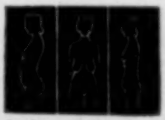

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Between Ourselves

We have often heard or used the expression "How does the other half live?" This month some answers are given to that query, particularly with reference to the health programs developed for the peoples in Finland and Denmark. Following the I.C.N. Conference in Stockholm, two of Canada's outstanding nurses attended specially organized refresher courses in those countries. Reading their reports of their experiences will cast a spell over you. We would draw your attention particularly to the fascinating account **Ethel Cryderman** has written of her visit to Finland. If you don't wish that you had been there too, we will miss our guess. Miss Cryderman, who is our national organization president, is superintendent of the Toronto branch of the Victorian Order of Nurses.

It is not often that we have the privilege of observing two facets of an author in one issue of the *Journal*. **M. Jean Wilson,** of the faculty of the School of Nursing of the University of Toronto, accompanied Miss Cryderman on these enchanting visits. She has given us an account of the developments in Denmark. She was also the Canadian representative chosen to participate in the program of addresses delivered during the I.C.N. Conference. We are pleased to present the thoughtful paper on aspects of clinical instruction and supervision on which Miss Wilson collaborated with **E. Kathleen Russell,** director of the U. of T. School of Nursing.

* * *

Every private duty nurse, during the course of her busy career, has had outstandingly interesting cases. The chairman of the National Committee on Private Duty Nursing, *Miss Barbara Key, 123 Bold St., Hamilton, Ont.*, has been able to provide a varied fare for their special page in the *Journal* with accounts selected by private duty nurses from their bulging files. **Muriel Ward's** informative paper on brain injuries in this issue is an apt illustration of the calibre of the material that is available from this group. Unfortunately, much of this instructive information remains hidden perhaps from a feeling of inability to write a lengthy article—perhaps because the nurses cannot find the time to write. In any event, Miss Key informs us that most of her contributors have been from Hamilton—that it is next to impossible to get any response from some of the other provinces. May we take this means of throwing down a challenge to private duty nurses elsewhere in Canada? Did you but know how much these articles are appreciated by the great body of nurses who are our readers we should be swamped with valuable material. If your problem is how to organize all the accumulated data, read **Jean Campbell's** account of the case studies program in effect at the Vancouver General Hospital. Will you take up this challenge, private duty nurses?

* * *

Nurses are taught from the earliest days of their training to keep cool, calm, and collected in any emergency situation that may develop. Whether they do or not is probably determined to a considerable degree by their emotional reaction at the time—according to the old saying, on "which side of the bed they got out of." That our emotions play a very large part in whether the day goes smoothly or not, we would all agree. That our emotional responses are directly responsible for both minor and major accidents may be a new thought to some of us. Dr. Norman L. Burnette presents some very interesting statistical proof of the role **emotional factors** play as the causative agents in motor accidents. Read his article carefully, then watch how often minor injuries to your person or your belongings reflect some form of emotional upset. Did you burn your finger on the iron because you were annoyed at getting off duty fifteen minutes late? It is a solid reinforcing lesson to us on how to keep our emotions under control.

* * *

Our attention has been drawn to an unintentional oversight in the September issue. The very fine summary of **Clinical Laboratory Procedures** by Dr. E. M. Watson was secured by the Community Nursing Registry of London, Ont., and was originally designed to appear on the Private Duty Nursing Page. Because of its importance to *all* nurses, it was used as our feature article and no credit was given to the private duty group for their share in securing this valuable contribution. Our apologies!

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Edited by **PROFESSOR F. N. HUGHES**

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Administration—Topically except in control of gastric hemorrhage, then orally.

NEURO-SPASEX TABLETS

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Description—Each tablet contains Homatropine Methylbromide 1/24 gr., Phenobarbitone ¼ gr.

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Description—Brand of Bethanechol Chloride (Urethane of beta-Methylcholine Chloride, Merck). Ampoules, 1 cc. containing 5 mg.; tablets of 5 mg.

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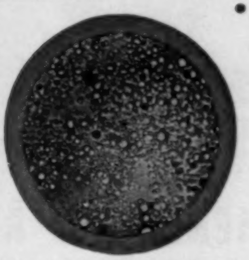

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"Don't cover up blemished skin!" warns lovely Mary Louise Shine, R.N. Yet it's amazing how many young women try to hide skin flaws—instead of using medication to help clear them up.

Beautiful Mary Lou Elliatt says almost every student nurse she knows keeps a jar of Noxzema handy for personal use. "I find it grand for helping clear up annoying blemishes," she says.

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Read how four typical young nurses solved *their* beauty problems

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The CANADIAN NURSE

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MONTREAL, NOVEMBER, 1949

Manners — the Happy Way

Average reading time — 4 min. 24 sec.

A SLEEPLESS PATIENT in a private room rings for a nurse in the wee small hours and timidly asks for a cup of tea. It might have taken five minutes to prepare it but the young graduate snaps, "You'll have to wait until breakfast time. I'm too busy to get you anything like that with really sick people to look after!"

A private duty nurse is seated at the desk in the ward office as the head nurse comes in. Her attention is focussed on her immediate work and she ignores the presence of the newcomer until she is asked to vacate the desk. Rather ungraciously, she rises and yields the chair.

A student nurse, receiving some instructions from her supervisor, stands with her arms folded, her weight shifted on one foot. She looks surprised, annoyed and hurt when comment is made upon her bearing.

What has happened to these people? Is this lack of thoughtfulness, of courtesy, a common trait in all walks of life? Are we being over-sensitive about these little deviations from the niceties of conduct in nurses? Do nurses, as a rule, recognize the rights of others, express their regret for seeming rudeness, show ordinary politeness even on ordinary occasions?

Henry Waldo Emerson wrote, "There is always a best way of doing everything, if it be but to boil an egg. Manners are the happy ways of doing things." What are "good manners" for nurses? Are they different in any way from the simple rules of courtesy that all young women should have learned from childhood? Are we being a bit stuffy? Is this attitude a throwback to the militaristic beginnings of professional nursing?

Gradually, throughout the nursing profession, there has been seeping in a calm disregard for many of the aspects of nursing ethics which have been honored in their observance over the years. Many have been heard to criticize the accepted patterns of deference to seniority, etc., as being out of line with present-day ideals of democracy. To these persons, such observances smack of a totalitarian system where all the lesser mortals must spring to rigid attention in the presence of the "elect." In their insistence upon their democratic rights, these nurses tend to swing to the opposite extreme and to ignore those precepts of good breeding that were instilled in them from childhood. Their lack of courtesy proclaims their "I am as good as you are" attitude. Is it possible it is only an indication of an underlying feeling of insecurity? If Emerson was right, that "Manners are the happy ways," then these people do need some form of help for surely they themselves are far from feeling tranquil and secure, gracious and happy!

What do we mean by "democracy in nursing"? That question can be best answered by defining our concept of democracy. In its political implication the accepted canon of democracy is *individual freedom:* the principle which declares that all are equal, whatever their rank, economic status or opinions. Hence, democracy is as much a system for protecting the rights of lesser groups as for asserting the rights of those in authority.

It follows, therefore, that the nurse who says she believes in democracy must be *tolerant* of the rights of others or her belief is not worth anything. Moreover, freedom itself can never be *absolute.* Any system, evolved to secure this relative freedom, rests upon expedients which are more or less adapted to the times, the circumstances, and the people. The promotion of these adaptations calls for a very *generous understanding* of people, their foibles and idiosyncrasies. Thus we see that, basically, democracy in nursing or any other profession rests upon tolerance and understanding. These are the very same considerations that are basic to courtesy and good manners.

Thus, democracy in nursing should mean thoughtfulness and regard for the needs, opinions, and attitudes of others—a mutual understanding between supervisors and students, staff nurse and head nurse, every nurse and her patients. The weary patient would have been mollified if the young graduate had said, "We are terribly busy here tonight—would you mind waiting a wee while until I have finished the list of treatments that must be done right now? Then I will make you a pot of tea." An understanding nurse thus makes a new, staunch friend for nursing. The private duty nurse who says, "I am sorry. I did not realize I was holding up your work here at the desk," will always be made welcome on that ward. And the student who has learned that relaxed good posture does not include folded arms and uneasily shifted weight is more receptive to suggestions from her supervisor.

Tolerance and understanding; a democratic way of life and courtesy; a simple please and thank you; there is a message for each one of us in the words "Manners are the happy ways."

New Brunswick Sets a Precedent

"Canadian Nurse subscriptions part of New Brunswick fee 1950."—A. F. Law

Thus tersely the momentous decision of the nurses of New Brunswick reached the *Journal* office.

For several years now we have been discussing with the various provincial nurses' associations and the C.N.A. the feasibility and convenience of having the subscription to *The Canadian Nurse* accepted by the nurses as a legitimate professional charge as is presently the practice in the medical profession for their official journal. We indicated the advantage to the nurses and to our *Journal*. Now, after many months of consideration, the vote has been taken and it can be said with truth that the whole body of the New Brunswick Association of Registered Nurses is solidly behind *The Canadian Nurse.*

New Brunswick has led the way in Canada and, we believe, in North America. Who will follow in their train? Which provincial association will be next?

If you want to kill time, work it to death!

Emotional Factors as Cause of Accidents

Norman L. Burnette, D.Sc. S.

Average reading time — 12 min. 6 sec.

Most accidents whether in the home, in industry, or on the highways can be fairly accurately classified as to cause. A person or a piece of machinery acts in a particular manner and the result is a mishap. But, with people, the underlying reason why they act as they do is not always disclosed in our too simple compilations of accident statistics.

Nurses know that human behavior can be affected by physical conditions and by emotional states. The first subject still is sadly neglected in our studies of causation.[1] Fortunately, the second is attracting thoughtful attention as advances in psychosomatic medicine tend to weave into a useable and harmonious whole the knowledge of the physician and the psychologist.

Psychology has been described as the oldest of the arts and the youngest of the sciences. The oldest of the arts, because I do not suppose that there ever was a time when man was not interested in what made his neighbor tick. The youngest of the sciences, because it is only within comparatively recent years that we have developed techniques of measurement worthy of being rated as scientific. Despite psychology's youth as a science, there has been enough serious investigation into accident causes to warrant the belief that not less than 10 per cent and perhaps 20 per cent of all so-called accidents, fatal or otherwise, are linked to behavior which has a deep emotional significance. Note the use of the word "all"— not just traffic accidents, not just industrial accidents, not just home accidents, not just accidents on the playing fields, but total accidents. Whether the end result of emotional behavior is an industrial accident, a traffic accident, a home accident, or an accident while indulging in recreation simply is a matter of circumstance or opportunity. Therefore, suitable data gathered by psychological studies of participants in one particular type of accident are a guide to tracing causation in other types of accidents, even though from the record-keeper's viewpoint the two classifications are at opposite poles—as for instance, certain types of motor car accidents involving adult drivers and certain types of accidents to young children.

It is possible to illustrate this thesis with pertinent data, from a study of motor vehicle drivers, conducted at the University of Western Ontario.[2] A preliminary measurement of the intelligence of the drivers responsible for the accidents indicated that there was no close correlation between accident rate and low I.Q.'s.[3] What is important is the information brought to light by Dr. Tillman's investigation of the social history of his cases. In a group of one hundred taxi drivers—divided into A, those with frequent accidents and B, those with low accident records—it was found that among group A six

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Dr. Burnette is assistant vice-president of the Metropolitan Life Insurance Co., Ottawa.

[1] The neglect probably is due to a too narrow interpretation of what is meant by "physical conditions." Perfectly satisfactory adjustments can be made to permanent physical handicaps. What the writer has in mind are temporary conditions causing interference with muscular co-ordination, vision, and judgment.

[2] I am indebted to the president of the University and to Dr. Tillman, research fellow in charge of the study, for permission to quote from the reports of Dr. Tillman's most valuable work.

[3] This finding lends weight to an opinion expressed by the writer in 1938 in a paper entitled "The Philosophy of Accident Prevention," to the effect that a sweet-mannered moron was no greater menace on the road than a highly intelligent boor.

times as many came from broken homes as did those in group B. In group A, four times as many had school truancy records as did those in group B. Over one half of group A had juvenile court records and, among these, a surprisingly large number had police court records for violation of laws other than traffic regulations.

Let us look at the personality structure of the men in group A as disclosed in careful individual studies. The common denominators in the years of early growth were disharmony in the home, resentment of authority, resentment of criticism, and resentment at attempts to suppress anti-social conduct. The study showed bad school records in respect to breaches of discipline and, in adolescence, junior gangsterism and the juvenile court. Dr. Tillman points out that when these youngsters reached adult life there was no maturing of philosophy. Instead, there followed a flowering of anti-social and amoral attitudes rooted in childhood conflicts, the remembrance of which were very close to the threshold of consciousness. Through dangerous driving these men compensated for the frustrations to which they had been exposed. Behind the controls of a powerful machine, they found opportunity to exercise aggressiveness, defy society and its laws and, like children, indulge in day-dreams in which one invites adventure and overcomes danger.

In fantasy, these men soared above the drab realities of life and became knights-errant, clanking along the highway in today's equivalent of shining armor. Thus has the twentieth century assembly-line enabled machine-age man to re-enact the fairy tale that has delighted people since the beginning of time. The only modern twist to the age-old fable is the sex angle. Instead of a long and arduous search ending in discovery of a maiden, cruelly confined in a castle, our motorized cavalier finds his partner with the greatest of ease and certainly suffering neither from restraint nor good old-fashioned inhibitions. Individuals such as these simply haven't grown up. They have childish minds in adult bodies.

There are certain phases in the evolution of the emotional life of children that have a bearing on a study of accident causes. First, the natural properties of childhood lead youngsters into paths of danger. This can arise from curiosity, the need to gain mastery over things, or because of a desire to emulate the behavior of loved ones. In proceeding to satisfy these urges, children are handicapped by rudimentary perception of space and time, a span of attention too narrow to take in all details, and a lack of understanding of cause and effect. These are elementary facts known to people trained in dealing with children. But children also perform actions which, as a background, have emotional patterns which are much more complex. It is not uncommon for very young children to identify inanimate objects with persons or with human significance or with their own feelings. One only has to watch the play of children, perhaps particularly the solitary child, to realize the truth of this statement. As Dr. Soddy has pointed out,[4] the destruction of a toy — very often a cherished toy—may signify that the inanimate object symbolizes a harsh or nagging adult or social restraints that irk the child and the bonds of which he desires to break. From the mistreatment of a doll, or some other toy, it is only a short step for a child to identify such things as motor cars or dangerous objects around the home with the attributes of persons or things that are disliked. Motor cars are commonly seen objects of great power and, therefore, easily lend themselves to the symbolization of parental anger, the truant officer, the policeman, or a too stern teacher. I have an idea that at times this form of fantasy enters into the problem created by

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(4) Personal communication to the writer from Dr. Kenneth Soddy, medical director, National Association for Mental Health, England.

teen-age cyclists. I have had the wits scared out of me by young bicyclists who, after escaping death only by *my* quick action, have rewarded my cleverness with a sneer, a thumbed nose, or a curse.

Second, children make a positive contribution to their own danger for reasons other than curiosity, desire for mastery, or desire to emulate. Their normal sense of helplessness contributes to bravado. They have to test themselves out by seeing how far they can go in defying the person or rules that control their actions. These growing pains in self-expression are not confined to humans. Young animals engage in actions which deliberately invite punishment. I once saw a bear in a wild state spank her two cubs under circumstances that any harassed housewife would have understood. If, in the case of children, the persons or rules become symbolized by objects capable of inflicting harm then, of course, you have the makings of a mishap. There is nothing alarmingly abnormal in this process of transference, nor is there anything abnormal about the urge to shake off restraints. The last is a natural phase in growth. There should be no insurmountable difficulty in controlling the rate at which a normal child "throws off." At first the controls have to be disciplinary in character. Later, in the various stages of maturing, reason, understanding, and the force of public opinion can be expected to act as controls. However, the child who is unsettled or insecure, or basically not happy in his relationship at home or school or in outside group contacts, is liable to develop an excessive degree of bravado in his desire to escape and also to create a life of fantasy of such intensity that it will color his later years.

Many adults never do mature emotionally. This, as we have seen, was the basis of the trouble with so many of the traffic violators. I suspect that some industrial accidents involving machinery are due to the projection of the emotional states of childhood into adult life. Otherwise, it is hard to explain why some individuals circumvent rules of caution and, at times, go to ingenious lengths to hurt themselves despite safety teaching and despite the provision of machine-guards.

Third, even in normal human beings, reactions to sensations are curiously mixed. While it may sound contradictory, there actually can be such a thing as enjoyment of pain. Some individuals invite bullying, nor is this confined to children. Others invite punishment and this can be carried to a point where there is an overwhelming desire to be seriously hurt. This interesting emotional pattern is not a simple one. Probably there are three main sources from which arise desire for pain. There can be anxiety about a secret knowledge of guilt in which case the pain is invited as an atonement or absolution. A wish for injury can arise from an intense desire to escape something more disliked than the invited physical hurt. Finally, among children and, tragically enough, among emotionally-starved adults, hurt can be desired as a means of attracting attention and affection.

I do not suppose that I was an unusual child. I think that I will strike a responsive memory in many minds if I admit that there were occasions when I wished that some dramatic mishap would interfere with my having to do something that I did not like. In fantasy I built up an alluring picture of myself as an interesting and uncomplaining accident victim waited upon by a loving and admiring household. I do not remember ever getting away with this. But children have been know to physically injure themselves as a means of avoiding disagreeable situations, as a means of attracting attention, or because of the blocking of emotions which discharged themselves through anger.

I would go so far as to say that in many accidents an inanimate object is listed under the heading of primary cause when, as a matter of fact, some sort of injury would have occurred in any event because the hidden but true cause was an emotional disturbance.

While an understanding of these emotional drives is important in the field of child study, *per se*, it has wider application because childhood attitudes tend to linger on to influence many adults in strangely uneven and unexpected ways. Dr. Tillman's study of accident-prone drivers uncovered a not inconsiderable number of adults who, starting life under unusual handicaps as children, never reached a state of normal emotional maturity. These are problem cases. No study of accident causation can ignore them. They are numerous enough to warrant attention.

In trying to arrive at the fundamental reason for an obscure type of accident, one could well start with recognition of the fact that reason and conscious knowledge are not the only governing factors in human behavior. The accident should be studied in its total social setting. In the case of children, imagination plays a large part in their mental life. Action is colored by fantasy as well as fact. Under stress, the first can overshadow the second. Among adults, probably to a greater extent than we realize, there are many who, unlike the apostle Paul, did not put away childish thoughts when they reached manhood. Accidents to these people are not solely due to simply explained behavior nor to external causes nor to anything that can be classified as carelessness. The cause is deeply motivated within the individuals themselves and arises from things which are part of their life pattern.

Nursing Education — Methods of Clinical Instruction

E. Kathleen Russell *and* M. Jean Wilson

Average reading time — 20 min. 6 sec.

> I merely utter the warning that education is a difficult problem, to be solved by no one simple formula.
>
> Get your knowledge quickly, then use it. If you can use it, you will retain it.
>
> To speak the truth, except in the rare case of genius in the teacher, I do not think that it is possible to take a whole class very far along the road to precision without some dulling of the interest. It is the unfortunate dilemma that initiative and training are both necessary, and that training is apt to kill initiative.
>
> . . . prolonged routine work dulls the imagination. The result is that qualities essential at a later stage of a career are apt to be stamped out in an earlier stage. This is only an instance of the more general fact that necessary technical excellence can only be acquired by a training which is apt to damage those energies of mind which should direct the technical skill. This is the key fact in education and the reason for most of its difficulties.
>
> The initial discipline of imagination in its period of youthful vigor requires that there be no responsibility for immediate action. The habit of unbiased thought . . . cannot be acquired when there is the daily task of preserving a concrete organization.
>
> The combination of imagination and learning normally requires some leisure, freedom from restraint, freedom from harassing worry . . .

From this background of thought from one of the wisest philosophers of the modern world, the late Professor A. N. Whitehead, we approach the question of the teaching of nursing, and the place in this of clinical practice and clinical instruction. Quite obviously, Professor Whitehead's philosophy would treat this clinical training as inseparable

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from the teaching of the whole subject, and indeed inseparable from the total content of the curriculum. Let it be accepted, therefore, from the outset that everything said concerning clinical instruction, the plans, the content, the method, the personnel, all these have meaning only if viewed in relation to the entire procedure in the teaching of the subject of nursing. Thus we start with a certain picture of a student for whom the teaching of this subject is devised: as a learner she passes from the classroom to the patient's bedside in a hospital ward, from hospital ward to a practice field in some community health service, thence back to the classroom or seminar table, or library, and so on in unbroken progress through all the closely-knit study and practice from which she derives excellence in the art of nursing. For present argument, the important feature of this concept is the mobility of both student and instructor, a mobility that sees no boundary lines, that recognizes no compartments, while both student and instructor move from one teaching site to another without even noting a change of scene.

DEFINING NURSING

Having placed the site of the instructor's work, it is possible to approach plans for the content and method of the teaching that she is to do. But first comes the need for another clear mental image or concept. What is the objective of this student of nursing? What is the purpose of the basic professional course being given her? In fine, what must the nurse be ready to do, or to be, as a qualified practitioner? This appears to be a difficult question to answer, though many are attempting to reply. From the recent, rather wide-spread, production of studies regarding nursing, we note the efforts at description from two thoughtful observers—Dr. E. Ginzberg of New York and Dr. John Cohen of London. These writers appear to be more than a bit baffled; and the reader appreciates Dr. Ginzberg's candor and restraint in refusing to venture a definition, though he continues to discuss the "proper task" of the nurse.

Dr. Cohen is more daring and we may start with his description though noting that it is very thin. With great economy of words, Dr. Cohen says that the nurse's function is "to lessen the incidence and duration of illness[2]." By virtue of its brevity, this description is usable momentarily to fix attention upon two of the significant sites of the nurse's activity: (1) at the patient's bedside (i.e., "duration") and (2) almost everywhere beyond the bedside, especially at all places where organized health work is in operation (i.e., "incidence"). But, even for the purpose of the present argument, this description by Dr. Cohen is not enough: it appears to ignore entirely another significant phase of the "proper task" which must be undertaken by nurses —namely, the conduct of education and research in their own professional field. Having added this, we have a picture of work which branches off in at least three main directions: work which is so varied, and potentially so extensive, that those who venture to mould opinion concerning the basic professional course in nursing must take their courage in their hands, and add wisdom and knowledge to courage. In her significant study entitled "Nursing for the Future," Dr. Esther Brown makes an interesting contribution to this thought when she speaks of nursing as "something so broad in scope and profound in nature that technical competence is only one of its components[1]."

LEARNING NEEDS

When this bald analysis of the future occupation of the young student is examined further, it indicates that she, the student, is required to be a learner in several directions at one and the same time. Broadly these overlapping sections of her curriculum include the following:

1. The acquiring of certain technical skills; skills which are: (a) numerous; (b)

greatly varied; (c) ranging from the need for simple manual dexterity to a demand for co-ordination of high intelligence with most delicate skill.

2. The acquiring of specialized knowledge pertaining to the practice of nursing, including knowledge of certain sciences, knowledge of medicine in its varied branches, and knowledge of social organization and practice.

3. As far as possible, the acquiring of general education to prepare this practitioner of the future to work with, and for, her fellow-men, both collectively and individually.

It is this general extension of our professional education that is causing so much controversy today. The problem is difficult but will be made even more so by those who attempt to over-simplify it. Recognizing the need for broad general education, we ask that studies in the humanities and social sciences be included, by some at least of our professional schools, in the basic course in nursing. It follows that the selected schools should give preparation in these subjects sound enough for later admission to any one of several fields of graduate study at the university level. Content as broad as this, when included, will lay a heavy demand upon the basic curriculum and upon the student; it is university work throughout and necessitates a fairly lengthy program. Heavy as this may be, it is worth a serious trial for there is considerable evidence to indicate that the student will benefit enormously when the general and the professional subjects are studied together in this manner throughout the whole extent of the undergraduate course.

It becomes fairly obvious, however, that the preparation of all professional nurses cannot be extensive enough to include all of this. Hence comes the inevitable conclusion that there should be more than one type of basic course. When the shorter type (non-university) is chosen—as would seem inevitable for a large majority—it should be made possible for the graduate of this to add further study later and to do so as economically as possible, though some of the deepest values of the broader basic training could not be salvaged in this disconnected type of preparation. This is one answer to the suggestion that all students in nursing should start with the same basic curriculum. The physical impossibility of such a procedure is obvious once the above objectives are accepted.

SUBJECT MATTER

Having fixed some thought concerning the purpose of professional education in nursing (either shorter or longer in extent), and the general nature of the whole basic preparation for this—i.e., the total curriculum—let us turn back again to the place of the subject of nursing itself in this total curriculum. It should be easier now to discuss, and to assess, the teaching of this subject. However, before plunging into this special topic, will you have patience to stop one moment longer in the effort to get an unprejudiced approach. Referring again to Professor Whitehead we find, in the above quotations, that he is speaking of professional education in general, and certainly not doing so with any reference to a nursing school. Hence his words give us the benefit of a completely objective opinion. Taking time to analyze and summarize his thought, we get suggestions which are surprisingly applicable to our subject. These proposals relate both to the content or subject matter and to the method of handling this subject matter.

Regarding the content. Professor Whitehead asks us to obtain: (a) technical excellence; (b) the development of initiative; (c) energies of mind to direct technical skill; (d) habits of unbiased thought; (e) development of imagination. Who will deny the importance of such a prescription for the subject of nursing?

Regarding the method. The demand includes: (a) variety—i.e., "no single formula"; (b) training—i.e., repeated routine work; (c) restriction of responsibility for immediate results; (d) freedom from restraint and from harassing worry; (e) restriction of responsibility for preserving a concrete organization (e.g., a hospital ward); (f) some leisure.

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TECHNICAL EXCELLENCE

All of this fixes thought very particularly upon the clinical teaching of our students and offers enough warning to give us pause about its possible dangers. And yet the fact remains that the young student of nursing *must* acquire "technical excellence," and we know that she must do this in a practice field fraught with very grave responsibility (i.e., for someone!), responsibility for the comfort and the safety of human beings whose very lives may depend upon the student's behavior. Seldom does any other laboratory in the whole group range of adult education offer such a situation. Admitting all of this, there is still no excuse for denying any of the broader claims of professional education. In fact there is good reason for suggesting that technical excellence itself will fall short unless these full claims are met. No wonder our mentor exclaims that education is a "difficult problem." If we could admit this one fact alone, nursing education would improve. Such an admission would brush aside traditional prejudice, and permit an approach to our task with the open-minded humility of the true research worker.

CONTENT

From this general educational philosophy we turn to the questions of content and method in the teaching of nursing. First comes content. Here lies the grave problem of selection. What shall be included? What shall be excluded? The professional courses may, and do, range all the way from two to five years in length but each one, even the longest, is faced continually with this necessity for choosing from an ever-extending range of material. All instructors must accept this fact and recognize that the difficulty will increase as medical knowledge increases. Regarding this selection of content, a recent writer, Dr. Elliot Dunlap Smith[6], (again with detachment from nursing), has interesting advice to offer. We note the following:

> **What is important for the student to possess on graduation is not (only) immediate knowledge, but the ability to acquire the knowledge that he needs at the time when he needs it.**
>
> **In order to have time to teach students to use knowledge, we must focus content on those *fundamentals* which are useful in later learning.**
>
> **In order to be able . . . to focus content on fundamentals and not have to teach students masses of particularized knowledge, we must teach . . . by methods that equip the student . . . to continue to learn . . .**
>
> **They (the instructors) are likely to lack the courage and vision to abandon the attempt to stuff their students as full as possible of information and techniques.**

Here in brief is the first chapter of the book of advice for all instructors in nursing. Some will heed it, some will not, for such restraint is hard to acquire. But, even if willing to follow such advice, do we know how to select the content which is basic? What for us are the fundamentals as distinguished from "the masses of particularized knowledge?" Obviously nursing education needs concentrated research upon these matters, and we must hope that this will be promoted under both national and international auspices.

Meanwhile experience can dictate some of the content for selection. Probably all will agree that the primary topic for the good clinical instructor is patient care. The student is in the ward to acquire the art of nursing, but she can learn to give good nursing only by practising good nursing herself, and by observing good nursing all about her as she practises. Thus the student will learn that nursing is good only when it is good for the patient and when it gives service as broad in scope as the patient needs. Under an able instructor, the student will acquire skill that is based upon knowledge and that becomes assured, well-organized, and economical in the use of time. This skill will include speed, but speed only in relation to the patient's needs: thus care will be given quickly or slowly as indicated. This same instructor will make sure that her student has an ever-increasing appreciation of the patient; and that she grows daily in the sympathy for, and sensitiveness to, his needs that mark the fine flowering of the art of nursing. Following considerations of this kind, the term "patient care" begins to expand in meaning, and the content of the subject expands simultaneously.

AN INDIVISIBLE SUBJECT

In organizing this teaching for young students, will our schools drop the habit of breaking the subject into fragments? As the mental and physical aspects of patient care are inseparable, let them be kept together by the nursing instructor; as the curative and preventive are equally interwoven, again let them be taught together, and, by the same instructor. She, the instructor, is teaching nursing and her subject should be indivisible, especially so during the early months of classroom and clinical teaching. This suggests an extremely comprehensive approach to the subject of nursing and lays a heavy burden upon those who teach. Readiness to face this task will grow with experience, as the instructor herself grows in knowledge and understanding of her subject.

METHOD

Next appears the topic of method. It is quite true that every good teacher makes her own method, but it is equally true that she can be given some help toward the making. For this purpose a certain few suggestions are added, though hesitatingly because so much of this is obvious. Methods in ward teaching and methods for the classroom are listed separately; although these are two parts of one whole, each part being always dependent upon the other. "Without theory, practice is unintelligent; without practice, theory is not understood."

METHOD IN CLINICAL TEACHING

1. An arranged order of progress through the various hospital services—all members of a class—(or section of a class) kept together in the same service: thus all associated classroom teaching made appropriate for all students in the class.
2. Teaching for the individual student at the bedside and also group teaching during which one student may help instruct others regarding her own patients.
3. Insistence from the outset upon good organization by the student of her most simple duties; and stress upon responsibility in small matters from the very first, with increase in responsibility as progress is made.
4. Controlled and uninterrupted practice periods; with appropriate clinical teaching during the night service as well as in the daytime.
5. No "harassing worry." Recognition of the fact that fear and strain lead to most undesirable results, such as the concealing of inadequacy; and that they may produce in the young student the sad change from eager zest to hard and cynical performance.

METHOD IN CLASSROOM TEACHING

1. *Before hospital practice is started:* The giving of basic knowledge, including adequate explanation, demonstration, and preliminary practice. One special device which has been found effective is to have a special day of introductory classes before entering upon each new hospital service.
2. *During practice periods:* Group conferences to question, to explain, to confirm, and to permit ever wider and wider application of the learning. Students will take a large part in the conduct of these conference classes.

This is only a skeleton outline of teaching method but there seems to be little more that should be said. A good teacher will make constructive use of the conditions in which she is placed: a poor teacher will not. And what makes a good teacher? Perhaps the description is as elusive as that of nursing itself, but all can agree upon certain qualities.

THE INSTRUCTOR

This "difficult problem" of professional education is one which demands an instructor with a keen and well-furnished mind, one capable of critical analysis but always constructive. She must start with a broad concept of nursing and develop this continually, with time, patience, and wisdom to do so even in the busiest hospital ward. With constant and eager vigilance this instructor will use every opportunity that her clinical teaching offers to illustrate and illuminate the academic studies of her pupils: humanistic and social students can be vitalized through this contact with patients. At the same time, patient care itself can be enriched by the greater insight afforded by these same studies.

The wise instructor knows that each student is an individual with her own possibilities, weaknesses, problems; and she knows that the rate of learning, development, and maturing must differ greatly with different individuals; therefore she will be too wise to expect an even pace. She knows that good student material may be slow to give indication of its potentialities. Finally, each member of the teaching staff in a nursing school should remember that a great variety of professional work awaits her pupils after they qualify and that many types of workers are needed Consequently the instructor should not want all to be cast in one mould. Of one thing she must make sure—that her students have opportunity to give nursing care that is satisfying to their patients and satisfying to themselves.

How are these instructors to be prepared? Obviously they need the best that is possible in both professional and general education; a high standard should be set for both. But this provides only the foundation. Much more is needed for which there is no formal preparation: no university degrees will assure this added learning. The only teacher at this stage is experience, but this experience needs to be found in a rich environment which will stimulate such growth, and provide the nourishment of thought and understanding which will make it possible for this growth to take place.

Conclusion

In conclusion we return to the "imaginative learning" for which Whitehead calls. We ask it first for our instructors and expect that they, in turn, will make it possible for their students. Some words written by Dr. Alan Gregg$_4$, in the dark days at the beginning of the war, emphasize this same thought. He told us then with encouraging, but qualified approval that "the nursing profession has known how to extend the boundaries of its usefulness by the relentless pressure of imaginative minds." May our schools be such that this relentless pressure continues.

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It has been estimated that 17 per cent of all married women never bear children. Because some of this childlessness is voluntary, it has been further estimated that in 1 in every 8 marriages it is involuntary . . . In the past an involuntary childless marriage too often has been blamed on the wife. This attitude has changed over the years and it is now estimated that the wife is responsible about 50 per cent of the time, the husband 40 per cent, and both about 10 per cent.

— *Medical Times*, Sept. 1949

The Study Course in Finland

ETHEL M. CRYDERMAN

Average reading time — 16 min. 24 sec.

THE STUDY COURSE arranged by the National Council of Nurses of Finland in Helsinki, immediately following the Conference of the International Council of Nurses, has become a cherished memory for the nurses from the fifteen countries who had the good fortune to attend it. The week in that beautiful land of lakes, forests, islands, and long clear nights was a delight; and the privilege of observing the progressive health program of a small but extraordinarily courageous democracy was both stimulating and challenging. Even more unforgettable was the warmth of our Finnish colleagues and their ability to express their welcome in such lovely ways. We felt we were long and eagerly awaited guests.

Miss van Bockhoven, the president of the National Council of Nurses of Finland, and her associates arranged a program designed not only to give us an insight into nursing education, nursing services, and public health activities in their country, but to afford us an opportunity to become acquainted with Finnish nurses and customs as well as to see as much as possible of Finland. The week was a composite of lectures, observation visits, and heart-warming entertainment. Hospitality was extended to us and we were guests at the College of Nursing, The Children's Castle, or at one of the hospitals. The first two days—Saturday and Sunday—were delightfully planned. The dinner on Saturday night was a happy occasion and many of us listened for the first time to the beautiful singing of Finnish folk-songs. One of the loveliest parts of our visit was the willingness of our hostesses, on the slightest suggestion, to sing for us.

A special early service was arranged on Sunday morning at Johannes Church at which the choir of the Finnish Nurses' League sang. Later, at breakfast in the church rooms, we were the guests of the women of the congregation. Then followed a sightseeing tour of Helsinki and a wonderful picture was had of the national capital with its outstanding examples of both the old and the very modern in architecture, its cultural institutions, its great parks, and its lovely Gulf of Finland. An especially interesting part of this trip was a visit to the House of Parliament which was conducted by Kyllikki Pohjola, a graduate nurse who is one of the 24 women members of Parliament. It was inspiring to hear Miss Pohjola refer to the recognition by state legislators of the relationship of nursing to the welfare of the people of Finland. The Finnish Red Cross entertained at luncheon and we were guests in private homes at small supper parties. During this very pleasant week-end, old friendships were renewed, new acquaintances were made, and an ideal atmosphere was created for the coming week's activities.

ANNEMARIE VAN BOCKHOVEN

THE COLLEGE OF NURSING

Finland's very modern and beautiful State College of Nursing was the headquarters of the study course. In it are housed a State School of Nursing, with accommodation for 300 undergraduate nurses, the State Post-graduate School of Public Health Nursing, and the more recently established Post-graduate Unit. Classroom teaching and recreational facilities are ideal. The personnel of the College is highly qualified and the large majority of the teaching staff has had post-graduate work in foreign countries. The College is a spacious, magnificently lighted, very gracious hall of learning. This great educational institution is the pride of the Finnish nurses.

The course was opened with a welcome on behalf of the State Medical Board by Venny Snellman, State Director of Nursing Education. She rejoiced that again it was possible to renew international contacts and have nurses from many lands visit her beloved country. What is so characteristic of the philosophy of a people who have suffered much was expressed by Miss Snellman when she said that happily they did not think about the dark days, that their concern was with the present and the future. During that week, as one became increasingly aware of the extensiveness of the present program and future plans for health and medical care in Finland, this truth was fully appreciated.

ORGANIZATION OF MEDICAL AND HEALTH CARE

The administration of medical and public health care in Finland is vested in a State Medical Board under the direction of a director-general. There are five nurse members of the Board, three of whom are primarily concerned with nursing, namely: the State directors of nursing education, public health nursing, and hospital nursing. The country is divided into administrative districts known as provinces and the provincial health officers are officials of the central government. Officers from the State Medical Board and from provincial health departments supervise the work of municipal and county boards of health. The majority of the hospitals in Finland are owned and operated by the state, municipalities, and counties. A municipality must provide at least one hospital bed per 175 population and a rural county, one hospital bed per 750 population. By law every county must have a sufficient number of beds in mental hospitals and in tuberculosis sanatoria. Treatment for venereal disease is free and compulsory. The law concerning general medical care makes it obligatory for every town and county to maintain a community doctor. He is a part-time officer of health and, as Finland has not a health insurance scheme, he is responsible for the medical care of indigents. Reference will be made later to certain significant legislation with respect to public health nursing and maternal and child welfare. The State is keenly interested in the provision of complete medical and health care for the Finnish people and the rapid progress

College of Nursing in Helsinki

Sitting-room in College of Nursing

View of Helsinki

which has been made during this recent difficult period is indeed amazing.

UNDERGRADUATE NURSING EDUCATION

The State maintains schools of nursing education and the State Medical Board appoints an inspector of nursing education. Schools of nursing are independent institutions and students receive their clinical experience at hospitals. Schools are administered by boards of governors, consisting of the medical officer of health, the matron, the director of the school and 2-4 persons appointed by the State. There are 11 schools of nursing education in Finland—7 state schools, 1 municipal, and 3 private.

The curriculum covers a period of three years. This includes a 4-month pre-clinical term. During the last 6-8 months students specialize in one of the different fields of clinical nursing, public health nursing, or midwifery. Preparation in the first two specialties is received at the Post-graduate School of Nursing and in midwifery at the Midwifery School. In three of the state schools public health is an integral part of the basic curriculum, and at these schools formal health teaching is received during the last six months. Accredited schools issue diplomas and these entitle nurses to state registration. It is interesting to note that student nurses are eligible to apply for a professional training grant from the State.

A State Commission on Nursing Education has published a report on the "Re-organization of Nursing Education" and has recommended the separation of the basic training from the training in specialties—the basic training to lead to registration and the specialties to become post-graduate training and to lead to higher competence. This recommendation is to become effective in 1950. Plans are also underway to conduct an experiment in the basic preparation of a nurse in a 2-year period.

At present there are both professional and non-professional nurse-midwives in Finland. There is, however, a growing conviction of the value, especially in the rural communities, of the public health nurse-midwife, and an experiment in the preparation of this type of nursing personnel is to be undertaken in the near future.

POST-GRADUATE NURSING EDUCATION

This education is centred in the College of Nursing. Here, in the State Post-graduate School of Public Health Nursing, a general course in public health nursing is conducted and refresher courses and institutes are held. Student practice work is received in a teaching centre and the Post-graduate School provides field instructors for its students. The need for additional preparation for public health nurses, who assume the more responsible positions, has been recognized and advanced courses in the supervision, administration, and teaching of public health nursing have been planned. The first course is to begin this fall.

The Post-graduate Unit in the College of Nursing was established in the fall of 1947. Although this unit is administratively independent, it has a close co-operation with the other units. On account of recent nursing legislation which, as yet, has not been enforced, and the fact that several members of the teaching staff have not completed their studies, to date compromises have been made in certain of the broader activities of this unit. Three-and-half-month courses in nursing education and administration of the hospital nursing service and a four-month course in medical-social work are conducted. It is planned at a later date to extend both these courses to cover two semesters of four months each. There are special courses in x-ray work, laboratory work, operating technique, and anesthesia. As nurses in Finland are responsible for administering anesthetics, this last course is of major importance. The Post-graduate Unit, although chronologically only in its infancy, is a quickly developing, mature, imaginative force in nursing education in Finland.

Functions of Nurses

It is interesting to note that a State Commission with 50 per cent representation from the nursing profession has been appointed to study the divisions of the functions of the nurse and specialists are to be employed to do job analyses. It is anticipated that the report of this Commission will affect future nursing legislation.

Auxiliary Nursing Personnel

One-year courses are conducted to prepare auxiliary personnel, both male and female, to work in mental hospitals. Children's nurses receive an 8-12 month training and are employed in hospitals, children's institutions, and by private families. In 1946, courses of an 8-month duration were organized by the State Medical Board for the preparation of "help nurses." These workers are trained primarily to care for chronic patients. However, experimentation is to be conducted to discover the extent to which it is possible to use "help nurses" in nursing other types of patients. All the above auxiliary nursing personnel work under the supervision of professional nurses.

Homemakers

The need for someone to care for the family when the mother is in hospital or away has long been recognized in Finland. Since 1939, mainly through the Mannerheim League which is a very active voluntary child welfare agency, 5-month homemaker courses have been available for women 18-35 years of age who have had a year's course in a state school of home economics. As the students in these courses have had a good foundation in housekeeping, the homemaker course emphasizes child care. The students receive practical experience in both children's institutions and in homes for old people. They are also given a short course in home nursing. The majority of the homemakers are employed by the Mannerheim League and they work in close contact with the public health nurse and the midwife. A bill to provide homemaking service is before Parliament and, if it is passed, communities will be required to employ one trained homemaker per 4,000 population. The State will assume the same financial responsibility as for the public health nurse and the midwife, and will either take over the training of the homemaker or delegate it to private organizations.

Public Health Nursing Service

Public health nurses: The Public Health Nursing Law makes it compulsory for every community to maintain a sufficient number of public health nurses. In rural areas the minimum is one to every 4,000 inhabitants. The duties of the public health nurse are: infant and preschool hygiene, school health service, tuberculosis service, control of contagious diseases and, when it cannot be otherwise arranged, bedside nursing care in the home. In some municipalities district nurses or deaconesses are employed by the community or the church to give visiting nursing care. However, their service is confined mainly to the aged and the chronically ill. The State pays three-quarters of the salary of the public health nurse and the midwife and the local community one-quarter.

Midwives: The Midwifery Law makes it compulsory to employ one midwife for each 5,000 of the population. The midwife assumes responsibility for prenatal, delivery, and postnatal service. The State, assisted by the Mannerheim League and the city of Helsinki, supervises the activities of both the public health nurse and the midwife.

Health centres: Another law makes it obligatory for every municipality and county to establish a maternal and child welfare centre. Often subcentres are required. These centres are subsidized by the State. The personnel includes a physician, at least one public health nurse, and a midwife. Throughout Finland there are some 556 central health centres and many hundreds of sub-centres. Through these centres, advice is available to mothers and infants, even in the sparsely settled areas of a country where geographical conditions create many obstacles in the provision of health services.

The Mannerheim League has been enthusiastic in its encouragement of the building of a "health house" in every community. It is felt that the work of those concerned with health services is most effective when there is a centrally located health house. This type of centre provides accommodation for the municipal health centre and contains a waiting room, examination and consultation rooms, a playroom for children, and other facilities according to the needs of the community. There are comfortable living quarters for the public health nurse, the midwife, and the homemaker. The waiting room is used for health exhibits, lectures, and conferences. Blueprints of several types of houses have been approved by specialists and, in order to receive financial assistance, a committee must select one of the plans submitted by the Mannerheim League. There are approximately 200 of these health houses in Finland. This large building project has, to a considerable extent, been made possible through gifts of money from at home and abroad. Two centres were visited—one at Malmi and one in a rural district—and it was a delight to see such attractive, well-equipped, and practically-constructed community health centres.

A Day's Journey

These all too few and very full days in Helsinki also afforded us an opportunity to make a day's journey through beautiful country to visit the well-known Kellokoski Mental Hospital. Here, in this progressive institution, we saw mentally ill patients working happily in surroundings which closely resembled private homes. We also heard about Finland's plan for mental health districts, each of which is to have a central hospital which will serve as a centre for mental hygiene and psychiatric work. The same day a visit was made to the Kiljavannummi Sanatorium for Tuberculosis. This institution, which is nestled in a woods of pine and birch on the shores of a lake, is one of the larger sanatoria.

Tuberculosis has always been one of Finland's major health concerns. Since her liberation in 1917 there has been a marked development in her tuberculosis program. By 1947, 27 institutions for the treatment of this disease had been opened since 1919. It is expected that, by the end of 1949, approximately 80 per cent of non-reactors to tuberculin will have received B.C.G. Under the recent Tuberculosis Act the country is to be divided into 19 districts, each with its own central sanatorium and 2-3 bureaux for preventive work. Finland is attacking the problem of tuberculosis with vigor and with a conviction that, through widespread preventive and curative measures, there will be a great reduction in the incidence of this dread disease.

THE CHILDREN'S CASTLE

The new Children's Castle, which was opened recently, reaffirms one's faith that occasionally in life dreams do come true. This unique Castle, which is one of the most beautiful children's institutions in the world, is owned by the Mannerheim League. It is a home for infants and children up to 10 years of age who require special health attention. It is also a training centre for children's nurses, student and graduate nurses, and midwives. The story of the securing of building funds is a fascinating tale. The architectural beauty and charm of the Castle is breathtaking and the details of the facilities for the care of the children and for teaching purposes exemplify what vision and a sense of beauty can accomplish. An account of the study course would be incomplete without at least a reference to this symbol of Finland's love for her children. However, as both the Children's Castle and the Children's Clinic, which is a very modern and beautiful hospital, merit much fuller descriptions than it is possible to include in this article, they are to be described in detail in a later issue of this *Journal*.

The most cordial hospitality was extended to us throughout the week of the study course. Visits to institutions were accepted as occasions to entertain us; a luncheon was given in our honor by the city of Helsinki; and invitations to dinner at private homes, as well as to spend June 23, the midsummer holiday, in the country, were received. The festivities of Midsummer Eve, which is always a joyous time in the Scandinavian countries, will long be remembered. The journey that night in boats, gaily decorated with birch boughs, to the summer house of the municipal nurses of Helsinki; the beautiful and colorful costumes of our hostesses; their songs of welcome; the outdoor Finnish games; and the good fellowship around the huge bonfire are unforgettable. What could have been more romantic than the boat trip home on that beautiful northern summer night! The many islands in the archipelago were lighted with bonfires and the sky was brilliantly illuminated by rockets. We parted at midnight on the quay in Helsinki after the singing of Auld Lang Syne. Very early the next morning several of us left Finland and the farewell songs of the student nurses in the hall at the College of Nursing was a last lovely gesture. The visit in that land of great beauty, where the spiritual and creative qualities of the people have had such a sustaining influence, was an inspiring experience.

Annual Meeting in Prince Edward Island

The twenty-eighth annual meeting of the Prince Edward Island Registered Nurses' Association was held in the Y.M.C.A., Charlottetown, with a business session in the afternoon and a dinner meeting in the evening. Forty-eight members registered.

The president, Mrs. Lois MacDonald, presided at both sessions. In her address to the meeting, the president spoke briefly of the passing of the new Act during the past year and which comes into effect January, 1950. She referred to the opening of a provincial office in Charlottetown.

Reports given by the various committees and sections, secretary, and treasurer showed an active year.

The guest dinner speaker was Dr. Kenneth I. E. MacLeod, of the Provincial Sanatorium staff, whose address on "Health and Rehabilitation" was enthusiastically received. Other guests present at the dinner were Hon. A. W. Matheson, Provincial Minister of Health, and Dr. Harold Shaw, chairman, Provincial Health Planning Commission.

Aarhus—Beside the Baltic Strand

M. JEAN WILSON

Average reading time — 5 min. 36 sec.

> *Small beside the big ones seeming,*
> *Time thou canst not have for dreaming,*
> *Yet there's greatness in thy name,*
> *Proudly born of saga-fame.*
>
> — CHR. RICHARDT

It was stimulating to realize that we had set foot in this small kingdom of four million inhabitants whose ancient history, folk high schools, and highly developed system of social legislation have aroused such wide interest.

The city of Aarhus, the second largest in Denmark, is situated on the beautiful east coast of Jutland. The Danish Council of Nurses had arranged a program of one week in this centre, following the I.C.N. Conference. The only graduate school of nursing education in Denmark was founded here in 1938. It is within the auspices of the University of Aarhus with some accommodation also provided by the Municipal Hospital and the University Hospital.

The program could be divided into three sections. There were:

1. *Lectures* which outlined medical care and social legislation in Denmark, the origin and development of the University of Aarhus, and the work of the graduate school for nurses within it. In a different vein was the hour which gave a graphic picture of the spirit of resistance as exemplified in Danish literature.

2. *Visits* were arranged to places of historical, cultural, and professional interest. Opportunity was provided to see Skovvangsvej, a housing arrangement for old age pensioners, and Braband, a home for old people, or to visit instead, Solbakken, the home for chronically sick children, and the kindergarten "Viborgaarden." Some of the group were able to go to the Keller-Institute in Brejninge for feeble-minded people and the Juelsmide Sanatorium for the treatment of non-pulmonary tuberculosis in children and grown-ups. One of the trips provided entrance to the health resort for "Invalids of Peacetime." Arrangements had been made to enable visitors to go to the hospitals—municipal, county, orthopedic, maternity, and psychiatric; and to learn something of the schools of nursing located within the first two of these hospitals.

3. *Social events* were another interesting feature. There was a dinner at the beautiful restaurant, "Varna," as guests of the local division of the Danish Council of Nurses The Mayor held a reception at the Town Hall. A tea party on the attractive sun-terrace of the university was given by the post-graduate school of nursing education and its alumnae association, and a garden party was arranged at the Municipal Hospital by the student nurses' association. Dinners in private homes were another form of friendly contact.

The graduate school for nurses is under the provision of the Ministry of Education. It is divided into three sections, each with its own director and assistant director. The administrative group is in charge of Ellen Broe, the public health group under Elizabeth Larsen, and the teaching group with Ellen Margrethe Schroder. Since 1938 they have had 649 students complete these courses of nine months each.

It is interesting to note that all public health nurses are employed by official agencies. Most public health nursing is specialized, though a combination of infant health work and school nursing has been practised increasingly the last few years. The visiting nurses are all registered nurses and give only bedside care. They are not expected to take up health education, apart from incidental teaching. In 1933 it was made compulsory for municipalities to provide for the nursing care of sick poor in their homes. There is a shortage of well prepared public health nurses but the policy has been adopted of doing an intensive type of work in the areas covered and leaving the rest of the country without such workers.

The graduates of both administrative and teaching courses find varied opportunities in the hospital field. For the population of approximately 4,000,000 there are 154 hospitals with 25,000 beds. The general hospitals are primarily under state, county, or municipal authorities. The country is divided into 23 counties. In each county there is at least one central hospital with segregated medical and surgical services, an x-ray department, and other special services. The number of central hospitals in a county may be increased according to the population. There are also smaller hospitals in the counties headed by a surgeon, with non-segregated services. With the exception of the one under the municipality of Copenhagen all mental hospitals are under the state, as are the two maternity hospitals. The tuberculosis sanatoria, the two institutions for feeble-minded people, two orthopedic hospitals, and the Finsen Institute for light treatment are under private auspices but with government support. I believe the three cancer hospitals, under the National Cancer Society, are almost without state aid.

The schools of nursing are connected with hospitals and number about a hundred. These are operated by the official authorities apart from two Deaconess schools and one Roman Catholic school. The number of students taken in annually is approximately 1,200. As part of the admission requirements, applicants are expected to have some training in housekeeping and to be between 19 and 25 years of age. The training covers a period of three years. At the end of the second year the students may join the trained nurses' association.

It was encouraging to learn that in the University Hospital of Aarhus (superintendent of nursing, Betty Gotterup) there are more trained nurses than students, without counting supervisors and head nurses. There is also a large group of ward maids. One typical ward of 32 patients had, as its day-time personnel, a supervisor, a head nurse, five staff nurses, five student nurses, and three ward maids. We were impressed, too, with the fact that a graduate nurse, after two years' experience, can be protected by pension. The number of graduate nurses in the country is approximately 19,000.

Though the period spent in this university town was a brief one, it was an extremely interesting and profitable experience. It was pleasant to meet again at least eight nurses who had studied in our own country. But the time came to leave the friendly, hospitable people and with regret we said good-bye. It is nice to recall—

There is a lovely land,
That proudly spreads her beaches,
Beside the Baltic strand,
A land that curves in hill and dale
That men have named Old Denmark . . .

(From the Danish National Song by ADAM OEHLENSCHLAEGER)

Syphilotherapy

There seems to be complete agreement that penicillin therapy is the treatment of choice for syphilis during pregnancy. One of the most important advantages is that treatment can be started at any time up to or near full term. There are no untoward effects on either mother or infant. This treatment should be combined with adequate prenatal care and postnatal follow-up.

Lost Immunity

Studies have shown that approximately 20 per cent of persons who were immunized against diphtheria in early childhood have lost their immunity by the time they enter junior high school. It would appear advisable therefore to apply the Schick test when these pupils enrol for school in the fall and wherever necessary give a "booster" dose of toxoid.

— Condensed from *Medical Times*

It does not pay to tether one's thoughts to the post of usefulness with too short a rope.

— JOHN DEWEY

Nursing Care Studies

JEAN CAMPBELL

Average reading time — 5 min. 12 sec.

THE INSTRUCTORS at the Vancouver General Hospital decided that each junior student should write nursing care studies in medical and surgical nursing rather than have examinations in these subjects. The student is required to prepare her case study under the guidance of the clinical instructor while actually engaged in work on the medical or surgical ward, as the case may be. Consequently, she describes an actual situation based on what she does herself and what she has observed being done by other personnel. A comprehensive study is made of an individual patient to bring out the fullest details of the nursing care that are needed. In this way, the actual care given is improved and, as a result of the concomitant instruction to the patient, he is prepared to return home, not only cured of his illness but also strengthened by the knowledge and ability of how to improve and maintain good health standards for himself and his family.

A nursing care study form, illustrated herewith, is given to each student. It covers four days of nursing care during which every angle is to be studied, with emphasis on the actual bedside care. The students have indicated that they have learned a great deal from the study. The instructors feel that it is preferable to an examination in which questions are asked without reference to the actual nursing situations in which the students are engaged. The summary of

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As a clinical instructor at the Vancouver General Hospital, Miss Campbell has had an excellent opportunity to evaluate the worth of this form of learning.

Patient's Name *Age* *Ward* *Diagnosis*

Previous history and symptoms

Significance of physical findings

	Pre-operative Day	*1st day Post-op.*	*2nd day Post-op.*	*3rd day Post-op.*
Significance of lab. findings				
Medications—reasons, results, precautions				
Nursing care—treatments, reasons, results, precautions				
Charting				
Health teaching				
Special problems				

a real situation carries much more weight and is a much sounder learning experience for the student.

The first step in the program is the careful selection of suitable cases. Occasionally, both medical and surgical nursing will be combined in the case of a single patient. Adequate direction and supervision is essential to assist the student in sorting out the multitude of details available. The study is then written up in essay-like form, using the same general headings as in the original research. Properly conducted, this exercise has some definite values in the education of student nurses:

1. She learns to recognize nursing care problems.

2. She is conscious of the correlation between her classroom lectures and the actual care of patients. She is forced to make a critical analysis of the immediate situation, relating her previous knowledge and experience to the specific condition found in the patient. By learning this scientific approach to a problem her future ability to cope with dissimilar problems is increased.

3. She becomes acutely aware of the patient as a person—an individual personality who perhaps needs the stimulation that an interested nurse can give. The patient's various symptoms and the routines and procedures that are carried out on his behalf are all part of the total picture. Thus, every treatment or test comes to be regarded as a definite step in helping that patient to recovery and not just ends in themselves. This emphasis on the personal needs of the patient adds considerably to the student's interest in her planning.

4. The logical next step in the student's thinking embraces the whole problem of the patient's home environment and his knowledge of the facilities that are available in the community for his health protection. Before she can give any counsel in this respect, the student must be aware of the opportunities herself. Thus her interest is spurred in the health and social aspects of nursing.

5. This leads on very naturally to a study of the agencies and organizations that can be utilized and stresses the importance of full co-operation between the hospital staff and such bodies as the local health department, the Victorian Order of Nurses, dietary services, visiting housekeepers, social agencies, etc.

6. The student must turn to reference texts for information in order to clarify every aspect of the particular condition in her mind. This form of introduction to professional literature is far more likely to produce a lasting impression of its value as a source of information than merely cramming facts from a text for an examination.

7. In like fashion, the student has to draw on her knowledge of widely varied subjects included in her curriculum. She gains an appreciation of the value of a solid grounding in such related topics as bacteriology, pharmacology, dietetics, psychology, sociology. The complete pattern into which all of these are woven serves to stimulate her desire and her search for more information.

One of the chief disadvantages of this form of learning is the amount of time it consumes. If the student is to produce a good, authentic nursing care study, not only must she have ample opportunity to observe her patient, read all of the reports on his file, and consult all the essential references but she must also concentrate on putting into effect the good nursing care she has planned and that the condition demands. On a busy ward this may prove a decided handicap when there is more work to be done than there are nurses to do it. Despite this problem, the results obtained more than justify the extra time involved. If it were possible to have each student make a complete nursing care study in each year of her training, we would have a valuable file for the estimation of her growth as a good bedside nurse and a sound health teacher.

The real tragedy of life is not in being limited to one talent, but in the failure to use the one talent.—Edgar W. Work

Nursing Profiles

Marion (Miles) Pennington has been appointed assistant director of the new school of nursing which has been opened this autumn at Dalhousie University, Halifax. Of United Empire Loyalist descent, Mrs. Pennington was born and educated in Cranbrook, B.C. She is a graduate of the Vancouver General Hospital and of the University of British Columbia, receiving her degree of Bachelor of Applied Science (Nursing) in 1932. She completed the requirements for her master of arts degree at Columbia University, New York, this year, majoring in counselling and guidance. She also secured her professional diploma as director of personnel in schools of nursing.

Mrs. Pennington's professional career has been varied and interesting. In 1933 she was appointed school nurse in Kelowna, B.C. Four years later she became supervisor of the health unit established at Abbotsford, B.C. She joined the R.C.A.M.C. in 1943 and was home sister in the C.W.A.C. Barracks in Washington, D.C. A year later she was transferred to the C.W.A.C. as social service officer for Saskatchewan, with headquarters in Regina. After the war, she served for two years with UNRRA as nursing supervisor of D.P. camps in the American zone of Germany.

Mrs. Pennington is tremendously interested in people. During her period of study in New York she was a member of the Committee on Friendly Relations with Foreign Students. Her experience and interest will be a great asset in her new work.

MARION PENNINGTON

Laura Mary Lambe has been appointed nursing superintendent of Metropolitan General Hospital, Windsor, Ont. Born in Toronto, Miss Lambe graduated from Wellesley Hospital there in 1925. After several years as night supervisor at Wellesley, she secured her certificate in teaching and supervision from the McGill School for Graduate Nurses and returned to Wellesley as instructor. In 1940 Miss Lambe went to the Peterborough Civic Hospital as instructor, transferring to Women's College Hospital, Toronto, in the same capacity in 1943. At W.C.H. she quickly moved to the fore, becoming director of nursing in 1945.

Miss Lambe has taken an active interest in professional nursing affairs. She has been chairman of District 4 and of the Committee on Nursing Education in the R.N.A.O. Her present appointment will benefit the students who are receiving their training under the experimental program sponsored by the Canadian Red Cross Society and the Canadian Nurses' Association.

LAURA LAMBE

Marjorie Elliott Jackson, A.R.R.C., has taken over her new duties as superintendent of nurses at the Brandon General Hospital, of which she is a graduate. Miss Jackson commenced her professional career doing general duty at the Hamiota (Man.) Hospital. From 1937 to 1939 she worked at the Peekskill (N.Y.) Hospital, returning to Hamiota as matron for a year before she enlisted with the nursing service of the R.C.A.F. From 1942 until the close of the war she was nursing sister and then matron at the R.C.A.F.

Burns and Plastic Surgery Hospital in Sussex, Eng. She was awarded the Associate Royal Red Cross medal for her devoted service. Following her discharge, Miss Jackson enrolled at the McGill School for Graduate Nurses where she received her certificate in administration in schools of nursing.

An unusual tribute was paid to Canadian nurses when **Bianca Mary Beyer,** during her visit to Denmark following the I.C.N. Conference, was made an honorary member of the Danish Council of Nurses. Throughout the years, Miss Beyer has been a wonderful friend to the nurses visiting Canada from the northern countries of Europe. Her friendships began when, in 1938, the Florence Nightingale Scholarship, awarded by the Canadian Nurses' Association, enabled her to study as one of the "Internationals" at Bedford College of Nursing, London, Eng.

Miss Beyer has been superintendent of nurses at the Runnymede Hospital, Toronto, since its opening in 1944. Prior to this period she served her alma mater—the Toronto General Hospital—as head nurse in the operating theatre and as surgical supervisor.

Ballard of Eaton's

BIANCA BEYER

Mildred Maybee has been appointed superintendent of the new 50-bed Leamington (Ont.) District Memorial Hospital which is expected to be in operation early next year. She will assist the board in outfitting the hospital during the interim.

In Memoriam

Marguerite O. Gray, who graduated from the Philadelphia Polyclinic Hospital, died at her home in New Glasgow, N.S., on August 16, 1949. During World War I, Miss Gray served overseas with the C.A.M.C. Following her return, she travelled extensively through the Maritimes in association with the Soldiers' Civil Re-establishment. After completing her public health nursing course at the University of Toronto, Miss Gray became the nurse for Pictou County. She continued with this work until ill health forced her to resign last March.

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Margaret Merle Harper, who was on the public health nursing staff with the Winnipeg Department of Health for twenty-five years, died on August 10, 1949.

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Natalie "Bibs" Ketchum, a graduate in 1935 of the Saint John General Hospital, N.B., died recently after a long illness.

Grace R. Martin, who graduated from the Royal Victoria Hospital in 1919, died on September 15, 1949, at the age of 62, from injuries received in an automobile accident. Miss Martin retired from the position of assistant superintendent of nurses at R.V.H. in 1946.

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Margaret (Hayes) McDonald, who graduated from the Saint John General Hospital, N.B., in 1923, died suddenly in Saint John.

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Helen Irene Robertson, R.R.C., who graduated from the Guelph General Hospital in 1907, died at her home in Drayton, Ont., on August 18, 1949, at the age of 66. Following graduation she went to the Dr. Howard Kelly Sanatorium in Baltimore, Md., where she was in charge of the radium department. Miss Robertson enlisted in 1914 with the C.A.M.C., serving as operating-room nurse in England, France, and Salonika.

Returning to Canada, she worked at Christie St. Military Hospital until 1927 when she became a staff nurse with the Canada Life Insurance Co. of Toronto. She had retired only a few weeks before her death.

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Ida S. B. Rosser, a 1912 graduate of Victoria Hospital, London, died in London on August 26, 1949, at the age of 80 years. She had been a supervisor at Victoria Hospital for many years. She retired from active nursing five years ago.

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Kathleen Isabel Sanderson, who graduated from the Royal Victoria Hospital, Montreal, in 1921, died in Vancouver on August 30, 1949. Receiving her certificate in public health nursing from the McGill School for Graduate Nurses in 1924, Miss Sanderson was active with the Victorian Order of Nurses for two years before returning to hospital work as assistant director of nursing at the Vancouver General. She was executive secretary of the Greater Vancouver Health League for six years. From 1938 to 1942, Miss Sanderson was honorary secretary of the Canadian Nurses' Association.

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Florence (Blakeney) Smith, who was for a time on the staff of Aberdeen Hospital, New Glasgow, died on August 14, 1949.

* * *

Jean Elizabeth (Donnelly) Watson, a graduate of the Hamilton General Hospital, died suddenly on August 14, 1949, at the age of 32.

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Molly Wellington, who graduated from the Medicine Hat General Hospital in 1926, died in Lethbridge on August 30, 1949, at the age of 45, following a lengthy illness. Mrs. Wellington had worked at the old Van Haarlem Hospital prior to her marriage.

Headaches

Most headaches are caused by emotional stress, it is indicated by five New York physicians in a report in the *Journal of the American Medical Association.*

Three of the physicians—Arnold P. Friedman, of the Headache Clinic Section, Mental Hygiene Service, Veterans Administration, and Charles Brenner and Sidney Carter, from the Division of Neuropsychiatry, Montefiore Hospital and Columbia University—conducted special headache clinics. They found that headaches for which there is no apparent physical cause and headaches following head injuries were by far the most common among patients.

Treating 494 patients with headaches of these kinds, they found that 50 to 60 per cent responded favorably to almost any medicine given them, and nearly as well to placebos — harmless but ineffective substitutes for drugs. Treatments used included psychotherapy, pain-relieving drugs, substances to constrict and dilate blood vessels, vitamins, and hormones.

Results of the study strongly suggest that the effectiveness of the medications was caused primarily by the patient's psychologic reaction to the treatment situation in general and to having received a "remedy" from the doctor, the article says, adding that both types of headache probably are "responses of the body to disturbing psychologic stress."

Dr. Robert M. Marcussen and Dr. Harold G. Wolff, from the New York Hospital and Cornell University Medical College, made a study of migraine headache. The typical sufferer, they found, is ambitious and tends to be a perfectionist.

"The natural outcome is tension, fatigue, and exhaustion; in this setting headache makes its appearance. Rage, resentment, and frustration are often common denominators of the emotional derangement preceding an attack of migraine. However, dramatic events need not precede headache—many follow long periods of so-called routine living with slowly accumulating tension."

Although the doctor can make the migraine patient aware of the cost of such a way of life, the decision of what to do about it is the patient's, the physicians emphasize.

The Newfoundland Tuberculosis Association has purchased a large motor vessel to continue its large-scale X-ray program in the province's remote outports.

Private Duty Nursing

Brain Injuries

MURIEL A. WARD

Average reading time — 15 min. 12 sec.

BRAIN INJURIES are divided into two major groups: (1) Those received by patients who remain unconscious for approximately an hour or longer from the time of the accident. One-tenth of cerebral injuries fall into this category. (2) Those who are dazed or who recover consciousness shortly after the accident. This group includes the remaining nine-tenths of cerebral injuries.

SIGNS AND SYMPTOMS

These vary, depending on the severity of the damage and other factors. The more serious cases include:

History of a severe blow on the head, followed by a period of unconsciousness which varies with the severity. During coma, a loss of sphincter control and general flaccidity, with absent tendon reflexes, especially in moribund cases. Respiratory irregularity. Sudden dilatation of the pupils and increase in pulse rate and temperature occur just prior to death.

The less severe cases are marked by the following:

Varying degrees of unconsciousness followed by disorientation which is often accompanied by delirium. Nausea and vomiting at first. Headache. Retrograde amnesia. Any form of somatic or cranial nerve palsy can occur.

Due to the numerous signs and symptoms the diagnosis is finally made on the history, together with the cerebrospinal fluid findings.

CASE HISTORY

On September 14, 1948, fifteen minutes after a car accident, Mrs. Murphy was first seen — deeply comatose, with contracted pupils, a slow feeble pulse, and stertorous breathing. Her limbs were flaccid; no bleeding from the nose was noted. This stout, fifty-year-old white woman was admitted to hospital one hour later. At this time, movement and moaning when tender areas were pressed, indicated the degree of unconsciousness. The pupils were equal, moderately dilated and reacted slightly to light. There was a half-inch laceration on the right occipital region surrounded by edema; no depression or fracture was palpable. Blood pressure was 100/80, pulse 100, thready at first. She vomited once after admission. Twenty-four hours later, Mrs. Murphy was still unconscious but could move all limbs and make grimaces when disturbed. The airway was clear and breathing regular.

On examination the findings were:

Cranial: There was no asymmetry of the face but she did not respond to pin pricks. The pupils were semi-dilated, equal and reacted to light; the fundi were normal, discs well outlined.

Motor: Tone was poor in all muscle groups —flaccid—but she was able to move all limbs.

Sensory: No response to painful stimuli was noted.

Reflexes: These were deep and all decreased to absent bilaterally.

These findings led to the diagnosis of cerebral laceration and contusion although there was no evidence of a localized collection of blood intercranially.

One week after the accident, Mrs. Murphy was still unconscious and appeared to have a right hemiplegia but the fundi showed no papilledema which would indicate a localized collection of blood on the left side, either extra- or sub-durally. Two weeks following

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Miss Ward is on the Community Nursing Registry, Hamilton, Ont.

admission she had a temperature of 104.4° which was controlled by nursing measures and medication. Three weeks after the accident her condition was noted as "stuporous." When awake she would watch all movements which came into her range of vision.

Her condition remained about the same throughout the next four weeks at which time she became weaker and did not respond. November 14 she was transferred to the Toronto General Hospital for an encephalogram and possible brain surgery; her condition was poor. Six days later she was returned and hospitalized here to be treated medically until her death on December 20, 1948, ninety-nine days after the car accident during which time she never fully regained consciousness.

Treatment

On admission the laceration was cleansed and a pressure bandage applied. The skull x-ray was taken and gave a negative reading. Temperature, pulse, and respiration were recorded every half-hour and the blood pressure every two hours for twelve hours. Thereafter, T.P.R. records were q. 4 h. and blood pressure b.i.d. Her record shows that the temperature hovered around 99° (per axilla), pulse 100-120, but the respirations were irregular—18-36. Blood pressure stabilized at 130/76-140/90, although the highest recording of the blood pressure was 158/86 which was twelve hours after admission.

Lumbar punctures were done at intervals and these showed:

The first—done the day following admission for diagnostic purposes: increased globulin; xx red blood cells; white blood cells, 42 per cu. mm.

The second—done 5 days after admission for diagnosis: xanthochromia; sugar, .122; chlorides, 735.0; total proteins, 15 mgm. per 100 cc.

One month after admission because of restlessness: chlorides, 700.0; globulin, no increase; sugar, .125; cell count, 2 per cu. mm.

The encephalogram done at the Toronto General Hospital showed no extra- or sub-dural blood clot but a softening of the brain with edema.

Diet

During the first four days Mrs. Murphy received her nourishment by an intravenous infusion of 5% glucose in saline, alternated with 5% glucose in distilled water. Because of restlessness it was very difficult to keep the intravenous running so it was discontinued in favor of Levin tube feedings which consisted of 100 cc. of the same intravenous preparations every hour up to 3000 cc. in 24 hours. Three weeks after admission the feedings were changed to a fluid diet containing cream, milk, orange juice, glucose and bakerlac in proportions of protein 80, fat 80, carbohydrates 140, producing a 1600-calorie diet. This was complemented with 1500 cc. of water to make the fluid intake 3000 cc. in 24 hours. Using this diet it was possible to remove the Levin tube with its constant irritation, and gavage Mrs. Murphy t.i.d. Beminal 1 cc. (I.M.) daily and ascorbic acid 100 mgm. *per os* supplemented the regular feedings.

Medication

No sedation was required during the first three weeks then Tuinal gr. III h.s. per rectum ensured a restful night's sleep.

Due to cerebral irritation Mrs. Murphy became quite restless and noisy during the day-time. On September 23 she had 100 cc. of concentrated plasma. (In cases where the restlessness is due to intercrania pressure concentrated plasma acts as a hypertonic infusion and assists the normal channels of absorption by upsetting the newly created osmotic balance.) This was not very effectual so codeine gr. I (h) p.r.n. and sodium luminal gr. II (h) p.r.n. were ordered. These were employed when the phenobarbital gr. I t.i.d. and triple bromides gr. XXX t.i.d. were insufficient. This was not a frequent necessity. During the last two and a half weeks of her life the moaning and restlessness increased to such an extent that the sedation was altered to sodium amytal gr. I t.i.d. and p.r.n. with morphia gr. 1/6 and hyoscine gr. 1/200 (h) if the sodium amytal proved inadequate. On several occasions the hypodermic sedation was necessary.

Duracillin, 300,000 units (I.M.) daily, was administered at various times when Mrs. Murphy showed a fever. This controlled any infection and her temperature soon returned to normal.

Nursing Care

"Maintenance of a free airway is considered to be of the utmost importance—

more important than any other therapeutic measure." The nurse may do this with pillows to prop the patient in a side position or place the bed in Trendelenburg's position. At times she may even have to hold the jaw forward. An airway may be necessary but a suction machine with a metal tracheal tip must be kept at the bedside. It is not the unconsciousness but the disturbed respirations of a patient suffering from a brain injury that are hazardous to life. In severe injuries the respirations are rapid and labored, at times employing the accessory respiratory muscles of the neck, although this "tracheal breathing" is usually seen just prior to death.

The importance of adequate concise records cannot be over emphasized. These should contain:

1. State of consciousness and the time noted; rational, restless (talking or not); responses to stimuli.
2. T.P.R. record as ordered—q.½ h. for 12-24 hours then q.4 h.
3. B.P. record as ordered—q.½ h. for 12-24 hours then b.i.d.
4. Pupils—equal, dilated (which one? when?); reaction to light.

An acutely alert nurse will be observant regarding any movements the patient makes —if she flexes her knee or knees, does she relax again? If so, record the time interval between these two movements. Picking at adhesive which holds intravenous or Levin tubes in place is a sign that the level of unconsciousness is decreasing.

A retention catheter eliminates incontinence of urine. Intake and output must be accurately recorded. This will ensure good functioning of the kidneys and aid in removing any toxins which may be present.

The nurse must maintain fluids, keep up nourishment, and prevent pneumonia. While the Levin tube was in place we noticed that large amounts of thick, tenacious mucus formed quickly. This required frequent oral hygiene and suction. A daily lavage with soda bicarbonate removed the mucus from Mrs. Murphy's stomach which otherwise would have caused regurgitation. Lavages were not necessary when the Levin tube was removed and the patient gavaged with a larger stomach tube.

Hyperthermia was controlled during the first two weeks by the use of ice-water enemas and on one day by a continuous ice-water colon irrigation. Thereafter the temperature showed some elevation but not enough to institute this treatment until the last three days of life when it proved useless.

Good bedside nursing care was necessary to prevent any breakdown of the skin from pressure. Pillows and small firm "doughnuts" protected the bony prominences while frequent changes of position took care of the back and sides. This frequent moving also helped to prevent pneumonia. Due to fecal incontinence, care of the back was carried out when necessary and at times the diet was changed to control diarrhea. This was complicated by Mrs. Murphy's diabetes which we controlled with regular and protamine zinc insulin and bi-weekly blood sugar estimations.

Great difficulty was encountered postoperatively with Mrs. Murphy's head. Because of the positions of the incisions it was hard to find an area on which she could lie without creating pressure and slowing up the already tardy healing processes.

Post-mortem examination revealed that the brain was slightly smaller than customary and showed evidence of edema, with congestion of the surface vessels. A small intercranial blood clot was found in the mid-brain.

Edema and Congestion

The absorption of cerebrospinal fluid depends upon an essentially equal pressure in both ventriculo-arachnoidal and cranial venous systems. Because of leakage from the arterial side of the intracortical capillary bed, the perivascular and perineuronal spaces become distended, causing an increase in brain volume. This results in congestion of the capillary veins which delays the absorption of the cerebrospinal fluid. This condition may progress until the intracortical veins rupture, causing perivascular hemorrhages. When this dilatation continues beyond an indeterminable critical point, the normal relationship existing between the capillary arterial hydrostatic pressure and the colloid osmotic pressure of the perivascular and perineuronal fluid is altered. The intravascular hydrostatic pressure is raised, fluid escapes into tissue spaces, and the perivascular colloid somatic pressure there is raised in relation to that of the blood plasma. As this perivascular pressure rises the amount of fluid escaping from the capillaries increases, causing compression of the capillary veins which in turn raises the intravenous pressure and upsets the normal absorption of tissue fluids. These back up and so make more pressure on the veins. This causes tissue anoxemia which results in intracortical and subpial hemorrhages due to the rupturing of small veins. Continued production of cerebrospinal fluid causes it to back up into the ventricles and cisternae until finally most of the cerebral reservoir is closed off by direct pressure of the surface of the swollen brain against the overlying dura.

CONTUSIONS AND LACERATIONS

Due to the free blood in the cerebrospinal fluid the normal intercranial pressure is increased. This causes edema and congestion which interferes with the absorption of the cerebrospinal fluid because the high cranial venous pressure is further increased. This additional increase is from backed-up spinal fluid which is prevented from escaping by the mechanical plugging of the normal outlets with free red blood cells in the arachnoidal villi. When the cerebrospinal fluid is heavily loaded with blood, one considers a severe and widespread injury, especially when there is profound unconsciousness. In severe injuries anemia of the medulla follows the development of high intercranial pressure which is succeeded in its turn by a spread of cerebral edema to this region, with the result that respiratory failure and death follow.

PROGNOSIS

In general, children and young people recover without disability following a brain injury. On the contrary, individuals over fifty years of age frequently do badly—in part, because their cerebral pathways are more definitely fixed, but also because a certain zest in life has gone and cerebral and physical activities are diminishing. Massive injuries may produce a permanent hemiparesis, aphasia, or marked mental deterioration but these are rare, largely because most of these patients die. Contrecoup frontal bruising may injure the olfactory nerves and cause a permanent loss of smell and ability to appreciate flavors. (Contrecoup injury is a bruising of the brain section opposite the direct injury caused by the bouncing of the brain, for example —a severe blow on the occipital region causes contrecoup bruising in the frontal lobes.)

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Glaucoma

Glaucoma is a serious cause of blindness among middle-aged and older persons. By one count it is responsible for 11 per cent of the cases of blindness in those groups. In the acute form, the eyeball hardens rapidly, there is intense pain, and the sight quickly fades. If the patient gets to an experienced eye surgeon quickly, this condition can be cleared up by an operation. Many a patient, however, supposes that he is suffering only from a severe attack of neuralgia and that eventually the pain will go away. By the time it does, surgery can do no good.

The chronic form attacks much more slowly. There may be no pain at first, but the patient may feel that he has to keep changing his glasses, and he will have periods of blurring. In addition to medical care, surgery may be needed. Like cataract, glaucoma may be an indication that something else is wrong with the system.

An eye examination before a child enters school is highly desirable. Perhaps one out of every ten children entering school for the first time has an uncorrected defect of vision, which school work is bound to make worse. As school work increases, the eyes should be examined again.

Public Health Nursing

The Nurse—Nutritionist Relationship in a Visiting Nurse Organization

ANNETTE ALLISON, B.A., M.Sc.

Average reading time — 4 min. 48 sec.

NUTRITION TEACHING is an integral part of public health nursing, whether in an official or voluntary agency. There are several reasons why this is so. First, the small number of nutritionists in Canada precludes the goal of reaching the public as a whole; second, the nurse, by virtue of her service, establishes an easy entrée into the home. Her powers of observation and philosophy help her to observe the conditions in the home, the facilities available for preparing and serving food, and the nutritive state of other members of the family as well as that of the patient. She is friend and counsellor to the whole family.

The nurse is the logical disseminator of nutrition teaching, for this can be done concurrently and in a matter-of-fact way during the care of the patient or during casual comment with members of the family. It is an important part of prenatal education and postnatal welfare. For example, when Miss M knocks on Mrs. A's door one sunny afternoon in April, she notes the forlorn bottle of milk sitting on the door-step. "Oh! Oh!" she thinks, "I know the milkman was in this district before noon. I must remember to ask Mrs. A about that." During the interview with Mrs. A the nurse comments on the importance of food to the growing baby, and that milk, left in the sunlight for any length of time, will be depleted of its vitamin B. She helpfully suggests that perhaps Mr. A could put up a little box on the porch into which the milkman could place the bottle of milk, if it is not convenient to bring it in immediately. She may wish to emphasize that the quart of milk Mrs. A drinks each day during pregnancy supplies her with almost the entire requirement of calcium and riboflavin as well as being an excellent source of protein.

The emotional factor in motivation is important in this teaching. Perhaps, for some reason, Mrs. A does not want to drink milk and purposely leaves it on the porch as an escape measure. When Miss M discusses the needs of the baby for protein and calcium in order to grow, Mrs. A thinks of the tender cuddly bundle that is growing within her, and the desire to do everything that she can for this new life stimulates her to drink milk and, indeed, to obtain all the foods necessary for herself and the babe.

The nurse acts as a co-ordinator of health education, integrating nursing, preventive public health measures, sanitation, and nutrition, all of which contribute to the public well-being. Also, while saving of the time of others, she saves the busy housewife from being bothered with many visitors. The nurse thus assumes a tremendous responsibility in the chain of health education. This does not imply that she must be entirely self-reliant in all forms of health education. She obtains help from physicians and from the nutritionist as a consultant.

In the visiting nurse organization, nurse and nutritionist confer fre-

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quently with reference to any difficult cases which the nurse feels she is not capable of managing herself. The nutritionist, having read more widely in the field, draws on her store of knowledge and may have suggestions to offer in dealing with the problem. Often a little discussion may bring to light other problems which have a bearing on the situation. Perhaps the family is having financial difficulties which complicate the problem of adequate nutrition for the patient. The nutritionist keeps close tab on changing food prices and is able to help frequently with the total budget, as well as suggesting less expensive substitutes for the higher priced foods.

Perhaps little Johnny will not eat for some inexplicable reason. The nurse suggests to Johnny's mother that the nutritionist may be able to help solve this problem. The nutritionist, in making the call to the home, first obtains knowledge of the case from the nurse and from the records, then discusses the situation comfortably with the mother, but out of ear-shot of Johnny for "little pitchers have big ears." The one way that Johnny can control his family may be by his refusal to eat. The nutritionist suggests that forcing a child to eat will not help but only makes for family scenes and resentment. Discussion may ensue regarding appetite and growth periods, on the serenity of meal-time, attractiveness of meals and size of meals for small children. Mother learns to think of Johnny as an individual with his rights—one who is worth getting to know, not as an encumbrance but as a delightful character.

These are but a few of the situations in which nurse and nutritionist co-ordinate their activity. In the educational program as a whole, new trends in nutrition are kept before the staff with news notes and at staff meetings.

The nutritionist acts as a consultant at staff meetings when case studies are made, as well as giving papers and leading discussion on topics such as normal nutrition, nutrition in special conditions, such as pregnancy, lactation, the infant and growing child, geriatrics, and in disease.

She assumes a definite role in the in-service training of the staff, beginning with an orientation period, where the nurse learns the co-ordination of nutrition teaching with that of care of the patient and education in public health. The standardization of technique in formula preparation is another important phase in the education of the staff nurse, in order that the rotation of nurses will not interfere with the teaching of this extremely important procedure.

Studies show that in Canada there are large numbers of people who are not properly nourished. Lack of knowledge regarding food requirements, lack of planning of diets for the family, poor apportioning of budgets, and crowded living conditions with the accompanying lack of cooking facilities lead to poor eating habits, snatched snacks and thus poor nutrition.

To teach people what constitutes an adequate dietary and to motivate them through interest, to the degree that they change their dietary habits, are the chief means of solving the nutrition problem. Only where physician, nurse, and nutritionist work together can this be done. The nurse with her knowledge of the family is the co-ordinator of this educational chain.

In the brief period since the end of the war, the average life expectancy of the industrial population has increased by about two years. In 1948, the average reached the all-time high of 67.16 years. The gain in the past seventy years is phenomenal. In the period 1879-89, life expectancy was 34.00 years. By 1911-12, it had risen to 46.63. It passed the 60-year average in 1935.

— *Statistical Bulletin*

Iron rusts from disuse, stagnant water loses its purity, and in cold weather becomes frozen; even so does inaction sap the vigors of the mind.—DE VINCI

Institutional Nursing

Psychometric Tests for Student Nurses

NORA STREET

Average reading time — 5 min. 12 sec.

REASONS FOR TESTS

GENERALLY SPEAKING, psychometric tests which are used prior to a course in nursing provide a basis for selecting potentially successful students for the nursing profession. They also assist an institution to prevent waste of their resources through failure to discriminate adequately between those who show promise and those who do not. More specifically, we may say that they improve personal, educational, and professional guidance of students by providing the faculty with objective information concerning the applicant. The tests frequently aid in diagnosis of learning difficulties as well.

The kinds of evidence and information, which are gathered by the tests, should indicate the applicant's aptitude for nursing to the extent that nursing aptitude is known at present. This data is summarized, reviewed, and appraised by a qualified psychologist, in terms of the standards of the school of nursing and the profession in general. It is felt that the material which is collected should include the applicant's intellectual capacity, her educational and cultural background, behavior and personality characteristics and, to a certain extent, her potential manipulative ability.

Information from personal interviews and references is necessary, but is it possible to obtain a wholly objective viewpoint in this manner? Standardized tests can provide objective evidence and comparable data with respect to essential abilities required for success in a school of nursing. Such tests permit a comparison of the performance of one candidate with all the other candidates tested. Schools of nursing are still handicapped by the lack of an adequate concept of nursing aptitude. Some there are who still believe "nurses are born, not made" and that tests should show some unique nursing aptitude which women in other professions do not have. No single test will, with any degree of certainty, demonstrate fitness for the study and practice of nursing. A complete all-round picture of the student is what is needed. This is secured only by administering many tests. The more tests given, the clearer the idea of the student's abilities will be. Psychologists advise against giving a limited number of tests.

TESTS USED

The type of tests used may have individual differences depending on where they have been compiled. Collectively, however, one group does not differ widely from another. The ones with which we are familiar are the following:

1. *California Capacity Questionnaire*, from which the psychologist obtains the:
    - Intelligence quotient;
    - Scholastic aptitude.

Language test data, which are particularly useful in indicating how well the individual understands relationships expressed in words, such as instructions, statements of principles, conference discussions, and the like.

Mrs. Street, who was formerly instructor of nurses at Holy Cross Hospital, Calgary, is now a member of the teaching staff of the Grey Nuns' Hospital, Regina.

Non-language test data, which indicate how well the individual understands relationships among things or objects when language is not involved, such as physical or mechanical relationships.

2. *Nursing Aptitude Science Test:* Students' knowledge of English grammar is shown in this test, also.
3. *Chemistry.*
4. *Arithmetical Ability Test.*
5. *Nurse's Silent Reading Test.*
6. *Social Adjustment Inventory*—consists of eight sub-tests: truthfulness; happiness; alienation; sympathy; purpose; impulse; judgment; control and wishes.
7. *Mental Health Analysis:* The least important, usually used to help the applicants become less nervous. This test shows liabilities and assets which, according to the psychologist, should balance in a normal, mentally healthy person.

USES AND LIMITATIONS OF TEST RESULTS

Pre-testing alone is not the answer to the problem of appraising and selecting applicants for schools of nursing. The tests do, however, provide objective, comparable data, which cannot be procured by the other commonly used methods such as the personal interview, the high school record, and the like. The data from tests, however, should never supplant the information obtained from other sources. Test results should be used in conjunction with such other information. There should be consistency in all reports from available sources. Whenever the level of achievement consistently shown in the high school record varies considerably with the test results, one or the other needs to be questioned. Was the candidate at her best on examination? Was she emotionally disturbed, perhaps about a situation at home? On the other hand, the student may possess greater ability than her high school record indicates. Such candidates should be re-tested.

PROFESSIONAL, EDUCATIONAL, AND PERSONAL GUIDANCE OF THE STUDENT NURSE

Studies have shown that as many students fail from lack of personal and professional adjustment as from classroom work. Early and effective guidance could, in many cases, salvage good professional material, which may otherwise be lost. Psychometric tests have been given to applicants at Holy Cross Hospital. The faculty feels that these tests have been of considerable value in understanding the reactions of the students to their studies, to their nursing practice, and to guide them through their studies. There are some students who do not work to the limit of their potentialities and others who aim beyond them. With these students, psychometric tests are invaluable.

Industrial Nursing Institute

A most successful Industrial Nursing Institute was held at Queen's University, Kingston, September 12-14, 1949. Nurses were in attendance from all parts of Ontario as well as about 10 from the province of Quebec, making a total registration of approximately 70 nurses.

Dr. R. C. Wallace, principal of the university, welcomed the group and opened the course by pointing out that industrial nurses, more than any other nursing group except the public health services, are concerned with the social welfare of people.

Since Queen's University pioneered in setting up a Department of Industrial Relations, and has as head of this department Professor J. C. Cameron, one of Canada's outstanding men in Industrial Relations, considerable time was devoted to this subject. Professor Cameron spoke on "The Nature and Development of Personnel Management" and "The Psychological Aspects of Employer-Employee Relations." The final period with him was devoted entirely to discussion and the nurses received much help in gaining a better understanding of their own position in relation to other departments and personnel within the plant.

Other phases of the work of the nurse in industry were presented by authoritative speakers. A demonstration period placed emphasis on the importance of good counselling techniques. Throughout the course, ample time was allowed for exchange of ideas and the nurses participated actively.

Aux Infirmières Canadiennes-Françaises

Les Problèmes de l'Infirmière Diplômée

JEANNE LAMARCHE

Lecture — 19 min. 12 sec.

C'EST AVEC PLAISIR que j'ai accepté de venir résumer devant vous ces problèmes. Je ne voudrais pas vous les présenter à travers une lunette pessimiste et si quelques-uns de ces problèmes semblent brosses en noir, c'est qu'ils nous ont été présentés à nous-mêmes comme faits vécus, ce qui nous enlève le droit de les ignorer.

Vous connaissez la plupart de ces problèmes et vous avez sans doute été tentées parfois de vous dire, "Hélas, moi, je n'y peux rien." Si tel était le cas, ce serait au moins déprimant et il vaudrait mieux nous taire car là, où on ne peut agir, dispensons-nous de parler.

Mais ne dégageons pas trop vite nos responsabilités. Ne pouvons-nous être convaincues que nous y pouvons chacune, individuellement, quelque chose, ne serait-ce que par le don de notre sympathie attentive, ou par une compréhension éclairée du problème de notre voisine.

Nous y pouvons quelque chose aussi à travers les activités de notre association professionnelle; de plus le fait d'étudier ces problèmes, de les reconnaître sincèrement n'est-il pas de nature à nous faire prendre conscience des inconvénients et des avantages de notre profession, nous évitant ainsi d'être inutilement frustrées dans notre évaluation de ce qui nous est dû? Rappelons-nous d'abord ce qu'est une infirmière diplômée. Cela nous permettra d'évaluer avec plus de justesse l'acuité de ces problèmes.

L'infirmière diplômée — c'est une personne d'une compétence professionnelle reconnue, possédant des qualités de dévoûment, de savoir-faire, qui la rendent capable de travailler au soin des malades ainsi qu'à la prévention et au contrôle des maladies. Pour les services qu'elle rend, elle a droit à des honoraires. Et afin de rendre plus efficacement ces services, elle doit veiller à maintenir son équilibre en prenant certaines heures de repos, en développant certains intérêts en dehors de ses intérêts strictement professionels, ce qui implique une vie sociale sagement organisée. A tout ceci, ajoutons une spiritualité bien comprise qui devrait parachever l'équilibre de ces diverses activités. L'infirmière est donc une personne humaine, profondément humaine, par conséquent, aux prises avec les problèmes ordinaires de la vie. Ce n'est certes pas son statut d'infirmière qui la protégera. Au contraire, il va même les lui compliquer parfois. Mais cela elle l'a accepté à l'avance quand elle a choisi une profession qui la consacrait au service d'autrui.

Quels sont donc ces problèmes spéciaux créés par l'exercice même de sa profession? Ils varient quelque peu suivant le champ d'action qu'elle a choisi.

Rencontrons d'abord celle qui débute mal. Nous l'accueillons à sa sortie de l'école, en larmes, à la dérive, amère, peu satisfaite de son école où d'ailleurs l'on avait jamais été satisfaite d'elle; elle n'a pas connu beaucoup de succès dans ses études; elle avait la critique facile, ne savait pas faire ses réclamations à bon escient, se montrait souvent dépri-

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mée; mais on l'a tolérée espérant une amélioration, ou parce que le personnel était restreint, ou pour tout autre raison. Mais avant de la laisser partir on lui a dit son fait; on a esquissé, à cette dernière minute, un inventaire peu flatteur de ses qualités et capacités. Lui a-t-on rendu service en le faisant à cette minute extrême? N'a-t-on pas détruit irrémédiablement sa dernière réserve de confiance en soi, en ses chances de succès? Si nous la suivons dans sa carrière, n'est-ce pas elle que nous retrouvons agressive, toujours sur la défensive en face de tout ce qui ressemble à l'autorité, toujours mécontente d'elle-même et des autres? Malheureuse! très malheureuse—problème de personnalité, problème d'orientation, problème de mauvais départ à vastes répercussions.

Rencontrons maintenant l'autre qui commence bien celle-là sa carrière. Elle a de l'ambition, de l'idéal, elle sait ce qu'elle veut: rester au service des malades. Elle aime la profession; elle désire d'abord acquérir beaucoup d'expérience, puis réussir, arriver à un poste de commande, s'amasser quelques économies pour les jours de retraite. Comme elle préfère à tout le soin des malades à l'hôpital, elle se dirige vers le service hospitalier: on lui offre pour débuter un salaire de $90 par mois, des heures de travail convenables. Elle est satisfaite de son sort. Les années passent, notre diplômée a acquis de l'expérience, et elle a atteint son salaire maximum de $150 par mois. Elle est encore assez satisfaite. Oh! Il y a bien une ombre au tableau: les chances de promotion sont réduites; les postes d'administration et de commande revenant de fait aux religieuses dans la majorité de nos hôpitaux. Mais elle accepte de réduire d'un cran son ambition. Mais voilà que tout à coup pour des raisons économiques, la direction la remercie de ses services afin de la remplacer par une jeune diplômée qui ne coûtera que le salaire minimum. Et l'infirmière perplexe se demande, tout en cherchant une autre position où elle devra recommencer au bas de l'échelle: "Une carrière dans le service hospitalier, a-t-elle nécessairement aussi peu de garantie de stabilité, de sécurité financière?" Rien ne protège l'infirmière contre le chômage, la maladie. Manque-t-elle d'esprit d'aventure?

Bah! se dit notre jeune consoeur qui est optimiste: "J'ai maintenant une bonne expérience des malades; faisons du service privé" et elle s'inscrit au régistre. Elle ne doit pas attendre trop longtemps parce que le travail ne manque pas et, bien entendu, elle passe à son tour car, dans le fonctionnement d'aucun de nos registres, on ne pourrait n'est-ce pas penser à des tours de faveur (ce qui pourrait créer de graves problèmes de rivalité, de mécontentement justifié). Ici encore, l'infirmière est contente des huit heures de travail reglémentaire, des honoraires raisonnables qu'elle reçoit. Mais elle doit faire un effort continu d'adaptation à son horaire de travail extrêmement variable: service le matin, l'après-midi, service de nuit. Ce changement de ses habitudes doit toujours se faire à si brève échéance qu'elle n'a pas le temps en fait de se créer des habitudes, mais cela la tracasse moins que le peu de sécurité du budget qu'elle ne peut jamais établir à l'avance. Rien ne la protège contre le chômage, rien ne lui assure du secours en cas d'invalidité ou de maladie, rien à part le projet d'assurance actuellement discuté. Cette insécurité encore là évidente est-elle génératrice de mésadaptation, de mécontentement? Peut-elle nuire à la carrière de l'infirmière? Le risque est-il plus grand dans son cas que dans celui des autres professions?

Un autre champ d'expérience est ouvert à l'infirmière désireuse de rester en contact direct avec le malade: le travail dans un bureau de médecin. Ici encore, le travail est intéressant, répond bien aux aspirations altruistes et scientifiques de l'infirmière, mais les heures de travail tardives laissent peu de place aux activités sociales, font perdre le contact avec les activités du groupement professionnel. C'est semble-t-il un problème d'éducation du public et surtout d'éducation de l'employeur médical.

Enfin il y a l'infirmière d'hygiène sociale. Celle-là on la dit l'enfant choyée de la profession; en effet son salaire est plus élevé (on oublie parfois qu'elle a dû fournir une année d'étude supplémentaire); ses heures de travail sont plus régulières et, comme elle est ordinairement employée par un service public ou une grande association, sa sécurité financière est assurée par un fonds de pension. Cependant, malheur à elle si elle est venue à ce travail sans les dispositions requises d'éducatrice; elle y sera fort désaxée, constamment mécontente du peu de succès et du peu de satisfaction qu'elle retire de son travail qui n'apporte jamais de résultats immédiats. Malheur à elle aussi si elle ne sait pas se retremper à chaque jour dans des pensées sereines pour préserver son équilibre. A côtoyer toujours la grande misère des taudis, des pauvres de coeur, des pauvres d'esprit, des misérables (dans le service social on ne voit pas beaucoup de luxe), elle peut devenir facilement démoralisée. C'est donc là un de ses problèmes de s'assurer d'abord de sa bonne adaptation et de se diriger vers un autre genre de service si elle constate avoir fait fausse route. Mais son problème à elle commence là où il lui faudra abandonner sa sécurité actuelle, assurée par un salaire régulier, et sa sécurité future préservée par le fonds de pension. C'est un dilemme! Doit-elle abandonner la sécurité économique et risquer la mésadaptation? Doit-elle préférer l'insécurité à la mésadaptation! Et le problème se pose presque dans les mêmes termes pour celle-là qui après, disons cinq ans de service dans une certaine agence, veut élargir son expérience et passer à une autre agence. La garantie d'un fonds de pension devient dans ce cas une entrave capable de consacrer la routine, capable de tuer le dynamisme. La sécurité financière ne pourrait-elle dépendre de l'association professionnelle plutôt que de l'employeur?

Il y a aussi le problème de celle qui désire poursuivre des études—sa soif de savoir, de vouloir faire mieux la lance à toute voile sur une mer orageuse d'insécurité. Elle doit envisager les dépenses extraordinaires de scolarité, des heures de travail presqu'impossibles, peu de chance d'une rétribution proportionnée à ses capacités lorsqu'elle aura ses diplômes. L'infirmière sera-t-elle condamnée à ne désirer rien de plus que la formation des trois années d'études à l'hôpital?

Enfin n'oublions pas les problèmes plus spécifiques de nos consoeurs des petits centres. Leurs intérêts matériels semblent protégés par le fait qu'elles appartiennent à une association soit professionnelle, soit syndicale mais, pas plus que nous, elles ne jouissent de sécurité matérielle. De plus, il leur est bien plus difficile qu'à nous de rester dans le mouvement. Comment pourrions-nous leur faciliter le contact avec l'évolution scientifique si rapide qu'il nous semble presque heureux à nous qu'elles aient le temps d'y réfléchir avant de devoir accepter toutes les données nouvelles?

Nous ne faisons pas ici mention des problèmes de l'infirmière religieuse. Il y en a certainement qui ressemblent aux nôtres; il y en a qui diffèrent des nôtres. Mais la religieuse fait partie d'une caste particulière qui la met à l'abri de nos inquisitions laïques et tout nous porte à croire que la grâce particulière de sa vocation l'a équipée de telle façon qu'elle n'attend plus rien de la terre et tout du ciel.

Que dire des problèmes de l'infirmière directrice d'école, directrice d'études, directrice d'un service particulier? Nous souhaitons qu'elle n'ait que le problème normal des chefs, à savoir: distribuer les tâches; voir à leur bonne exécution. Si ses problèmes personnels n'ont pas été résolus avant son arrivée à la direction, c'est son incapacité même qui engendrera ses problèmes personnels et multipliera les problèmes de ses subordonnées. C'est le cercle vicieux. Si l'on ne sait voir ses propres limites, si l'on vise trop haut pour ses capacités, on développe facilement des conflits personnels qui réagissent sur le bon équilibre de la communauté.

Il découle de ce que nous avons

essayé de concrétiser que les problèmes de l'infirmière diplômée semblent surtout à base d'insécurité économique, de stabilité précaire des emplois. Est-ce là un hasard professionnel qu'il faut envisager avec courage en développant le goût du risque, de l'aventure, du détachement? En second lieu apparaît le problème de mésadaptation possible soit par erreur d'orientation, soit par une évaluation erronnée des capacités personnelles. C'est un problème qui ne nous est pas particulier sans doute mais auquel nous n'échappons pas. Enfin, problème non essentiel peut-être, mais de grande envergure, problème de la difficulté d'imprimer à nos loisirs l'orientation professionnelle et culturelle capable d'élargir nos horizons, de nous prémunir contre l'enlisement dans la routine.

In the Good Old Days

(*The Canadian Nurse, November, 1909*)

"A nurse may choose to nurse tuberculosis, but it is scarcely in her power to choose not to nurse it. In what direction, indeed, can she be sure of escape? . . . When the lessons of the post-mortem room have been well learned, when it is realized that tuberculous lesions are found after death in many more than half of all people . . . it may be seen that a nurse may no more keep clear of tuberculosis nor remain blamelessly ignorant of it than she may be of asepsis and antisepsis . . . By what means can it be arranged that no nurse can avoid learning much more than the average nurse now knows about its various phases and the general principles of its treatment?"

* * *

"The strain and tax on mind and body of those who nurse neurasthenics is such as can be understood only by experience, and requires a physical constitution that few nurses possess to enable one to continue long in such practice."

* * *

"Pupil nurses should not be called upon to give more than 63 hours per week to their work, including class hours and exclusive of time off duty. Emergency work out of hours, or overtime work, should be repaid pupils as soon as possible. All time lost by illness of pupils should be made up at the end of the course."

* * *

"The nurse's profession is nobler even than the physician's, for the latter has not the constant attendance on his patient, which is the nurse's duty; therefore, hers is the higher calling, because it gives occasion for a more extended exercise of the Christian virtues of patience, humility, and silence."

"On August 28th the Lachine General Hospital, in affiliation with the Victorian Order, was opened."

* * *

At the graduating exercises of one hospital, among other special medals that were awarded was one given for "cheeriness on night duty."

* * *

"One of the best meetings of the Manitoba Graduate Nurses' Association was held on September 27th. There were fifteen members present and all seemed interested."

* * *

"Miss Jean Wilson, of the G.P.H., Ottawa, is head nurse in the operating theatre of the new General Hospital opened in Vernon, B.C."

* * *

"It is expected that the beautiful new General Hospital at Calgary will be ready some time in December. The board is in the happy position of having enough money to finish the building."

Rules

Eat less; chew more.
Waste less; give more.
Ride less; walk more.
Go less; sleep more.
Talk less; listen more.
Worry less; work more.
Idle less; think more.
Preach less; practise more.
Clothe less; bathe more.
Scold less; laugh more.

—*Unknown*

Trends in Nursing

Average reading time — 9 min. 36 sec.

Executive Committee Meetings

The General Executive Committee meetings of the Canadian Nurses' Association will be held in Montreal from November 7 to 12.

On the first two days, the provincial registrars will meet to confer on the many problems that must be met and solved by Canadian nurses. This will be the third such meeting that has been held by the Canadian Nurses' Association.

Student Participation in the Biennial

The student nurses who attended the last biennial meeting in Sackville were unanimous in their expression of appreciation of the opportunity to learn something of the professional organization of which they soon were to become a part. A National Student Nurses' Association is in the process of being born and students attending the biennial meeting next year will have the opportunity to help determine the policies of this new organization.

Every nursing school will, therefore, want to be represented at the 1950 meeting being held in Vancouver next June, and a very cordial invitation is extended by the C.N.A. to the students of Canadian nursing schools. We will be looking forward to seeing their fresh young faces. The national convener of Student Nurse Activities is sure to have something interesting up her sleeve for the students. Watch this column for further details.

Expert Committee on Nursing

It has been proposed at headquarters of World Health Organization to set up an Expert Committee on Nursing. Daisy Bridges, R.R.C., executive secretary, I.C.N., speaking on this proposal mentions several points that are worth repeating—namely, that the International Council of Nurses is a self-governing, non-political federation of national nurses' associations from all over the world; the national nurses' associations in thirty countries are in full membership; sixteen other countries have associate status; the Council represents on an individual basis approximately 350,000 nurses. The objectives of the I.C.N. are the maintenance of the highest standards of nursing service and of nursing education in the countries which are in membership and the attainment of such standards by countries not yet in membership.

Miss Bridges states that the collaboration of nursing is an essential feature in the various priority programs of World Health Organization. She mentions the consciousness in most countries of the grave shortage of trained personnel for nursing service, and discusses some reasons for shortage and the need for more specific information on how to make supply meet demand. She closes with the plea that if and when an Expert Committee on Nursing is set up—

> This committee should consist of a majority of nurses, and that these should be most carefully selected, not only for the essential contribution which they would inevitably make from their own respective countries, but that they be persons with international vision through association with other international organizations in the field of health.

In conclusion, Miss Bridges enumerates the I.C.N. committees working on nursing problems and expresses the hope that the results of the researches being carried out by the various committees "may be used and co-ordinated by an Expert Committee on Nursing at such time as it is set up, in order that this material may be of the greatest possible usefulness to World Health Organization and through it the countries it is set up to serve."—*Nursing Mirror*, July 30, 1949.

Men in Nursing

We occasionally have inquiries from men nurses, usually from countries other than our own, regarding the possibilities for a nursing career in Canada. An article printed in *Public Health Nursing* for August, 1949, which quotes from "1948 Facts About Nursing," intimates that schools in the United States are showing an increasing interest in the male student. In January, 1949, there were 123 schools admitting men students and men students enrolled at the beginning of 1948 numbered 455. Public health nursing organizations are evincing interest in the male applicant. "Men Nurses in Public Health Nursing," also appearing in the August number of *Public Health Nursing* and written by a male nurse, presents what appears to be an authentic picture of the work that can be accomplished by a male public health nurse.

Extension of Welfare Service

With the inclusion of the Yukon Territory, the benefits of the Federal Old Age Pensions Act now extend to every province and territory of Canada for the first time since the Act was passed in 1927. All provinces, with the exception of Newfoundland, have advised the Federal Government of willingness to sign an agreement approving an increase in old age pensions which will provide for a raise in the basic pension to $40 per month.—*Welfare*, July, 1949.

Tuberculosis Nursing at Miller Bay

The *Canadian Association Tuberculosis Bulletin* for July carries a brief comment on nursing at Miller Bay Hospital, recently taken over from the Royal Canadian Air Force by the Indian Health Services. Here, under pioneer conditions, our people of Indian extraction are treated for tuberculosis. According to the article, the tribulations of the staff during the early months were many but, after 28 months of operation, there is now accommodation for 160 patients and every bed is filled.

Service for Patients with Arthritis

Out-patient department, diagnostic treatment service, in-patient centre, and mobile unit comprise the pilot scheme which is to be the nucleus of a province-wide service for the treatment of arthritis and rheumatism in British Columbia. Patients are referred through their family physician or through the pilot arthritis centre.

Treatment is available to everyone regardless of ability to pay and, when indicated by circumstances, medication is available free through the outpatient department of the Vancouver General Hospital. Three physiotherapists are employed and those unable to leave their homes are treated by the society's physiotherapists who travel with *all* necessary equipment. An intensive educational program is being carried on.—*Welfare*, July, 1949.

The Tenth Province

Health services in Newfoundland are described by Dr. James McGrath, assistant director of medical services, Newfoundland Department of Health, in the August issue of *Canada's Health and Welfare*. Dr. McGrath tells us that there are 1,500 settlements scattered along a coast of at least 6,000 miles. "Distance, isolation and thinness of population, together with lack of transportation facilities, all contribute to the difficulties of getting service to the individual in time of need." Medical services tend to be concentrated in the capital of St. John's. There is a large general hospital, a tuberculosis sanatorium, a hospital for mental and nervous diseases as well as two private hospitals operated by the Sisters of Mercy and by the Salvation Army. There are also fourteen districts organized on a contributory fee basis and with care centred in cottage hospitals. This plan is the backbone of the medical service to families in outlying districts. The head of the household pays a yearly fee of ten dollars. For this, he and all dependent members of his family receive necessary medical service, including hospitalization. The district nursing service, planned to bring nursing and a degree of medical service to isolated and thinly populated areas, has suffered more than any other from the shortage of nursing personnel. Tuberculosis is one of the greatest public health problems. All tuberculosis services are free to any citizen and free x-ray diagnosis is available at some twenty centres. Free immunization against whooping cough and diphtheria is available as well as free treatment for venereal disease.

There is a close follow-up of lapsed or recalcitrant cases and the act has effective powers of coercion which, however, are only employed as a last resort when all other measures have failed.

Moving Forward

A brief report of a *Nursing Mirror* week-end course in Human Relations appears in this journal for August 6, 1949. The group attending the discussions represented hospitals and public health nurses from the administrative and teaching field. The discussions centred around incentives, individual in relation to group, and interviewing techniques; problems of human relationships and propaganda for nursing recruitment. Mrs. B. A. Bennett, who discussed the last topic, reported that there was a net increase last year of five thousand student nurses and expressed the opinion that the "profession would have enough recruits to be able to be selective."

Trends in Australia

An important recent event in Australia is the organization of the first College of Nursing on a federal basis. The College is to be administered by a Federal Council of twenty which will consist of equal representation from each State, one from the Northern Territory, and an independent chairman. Provision is made for state committees which will work under the direction of the Federal Council. Post-graduate education will be provided for ward sisters, sister tutors, and hospital administrators. The initial headquarters of the College will be in Victoria but there is nothing in the memorandum and Articles of Association binding it to any one State. The main objectives are that the College be a national one to provide post-graduate education for nurses and that its diplomas be recognized in all parts of the world. —*The Australasian Nurses' Journal*, May, 1949.

New Books

Through courtesy of the Joint Tuberculosis Nursing Advisory Service, National Office has recently received copies of two books on tuberculosis both of which should be of interest to Canadian nurses. "Safer Ways in Nursing to Protect against Tuberculosis," prepared by the Joint Tuberculosis Nursing Advisory Service of the National League of Nursing Education, National Organization for Public Health Nursing, and National Tuberculosis Association, is a 107-page treatise on principles and their practical application. This guide gets off to a good start with a chapter of definitions and one on basic concepts. There are good references at the close of each chapter, an appendix of additional information, and a self-appraisal form for administration, all of which add to the usefulness of this practical little book.

"The Instructional Plan for Basic Tuberculosis Nursing" by the subcommittee on Tuberculosis Nursing of the Committee on Curriculum, co-sponsored by the Joint Tuberculosis National Advisory Service, is intended as a supplement to the Curriculum Guide for Schools of Nursing and outlines a program for the teaching of tuberculosis nursing

in the basic course. A bibliography dealing with all phases of the tuberculosis problem is included. This 58-page manual should be of value to any instructor who is including a course on tuberculosis nursing.

Orientation et Tendances en Nursing

Réunion du Comité de Régie de l'A.I.C.

Le Comité de Régie se réunira à Montréal du 7 au 12 novembre. Durant les deux premiers jours les registraires des associations provinciales se réuniront en conférence et discuteront des nombreux problèmes qu'elles ont à solutionner. C'est la 3e conférence de ce genre, tenue par l'A.I.C.

Les Etudiantes des Ecoles d'Infirmières au Congrès de Vancouver

Les étudiantes, qui ont eu le privilège d'assister au congrès de Sackville, ont été unanimes à dire combien elles avaient apprécié ce qu'elles avaient appris sur les organisations professionnelles dont bientôt elles seront membres.

Une association d'étudiantes est en voie d'organisation, et les élèves qui assisteront au congrès auront l'occasion d'aider à formuler la politique de cette association.

Chaque école d'infirmières voudra alors être représentée au congrès de 1950 à Vancouver, en juin prochain. L'A.I.C. invite toutes les étudiantes des écoles d'infirmières du Canada. Nous anticipons le plaisir de voir ces minois éveillés. Un programme intéressant sera préparé à leur intention.

Un Comité du Nursing à l'O.M.S.

On a proposé aux quartiers généraux de l'Organisation Mondiale de Santé d'établir un Comité du Nursing, composé d'experts de la profession. La secrétaire du Conseil International des Infirmières, en parlant de cette proposition, souligna plusieurs points qu'il est bon de rappeler ici.

Le Conseil International des Infirmières est autonome. C'est une fédération, sans caractère politique, des associations d'infirmières de toutes les parties du globe. Les associations nationales de 30 pays sont membres de la fédération et 16 autres sont associés. Le conseil compte 350,000 infirmières comme membres individuels.

Les buts du C.I.I. sont de maintenir dans les pays (membres du conseil) les plus hauts standards tant au point de vue service des malades, qu'à celui de la formation de l'infirmière, et d'atteindre ces mêmes standards dans les pays qui ne sont encore que membres associés.

En plus, ajouta Mlle Bridges, la collaboration des infirmières est essentielle à la réalisation des programmes reconnus d'importance primordiale par l'O.M.S. Elle mentionna que l'on se rendait compte dans presque tous les pays de la pénurie d'infirmières qualifiées et elle discuta les raisons données comme cause de cette pénurie et sur la nécessité d'avoir plus d'information sur les moyens à prendre pour que l'offre réponde à la demande.

Comme conclusion, si l'O.M.S. organise un Comité du Nursing, dit-elle, nous espérons que ce comité sera formé en grande partie d'infirmières et qu'elles seront choisies avec soin, non seulement en tenant compte de la contribution qu'inévitablement elles apporteront de leur propre pays, mais en tenant compte que les personnes choisies aient des connaissances sur les questions internationales du nursing et des relations avec les autres organisations internationales en matière de santé.

En plus, Mlle Bridges énuméra les différents comités du C.I.I. travaillant à solutionner les problèmes du nursing et elle espère que les recherches faites par ces comités seront utilisées par le Comité du Nursing de l'O.M.S.

—*Nursing Mirror*, le 30 juillet 1949

Des Hommes Comme Gardes-Malades

Nous recevons des demandes de renseignements, la plupart du temps venant d'autres pays que le nôtre, d'hommes gardes-malades (male nurse) concernant les avantages qu'il y aurait pour eux à exercer leur profession au Canada. Dans le *Public Health Nursing* pour août, 1949, on rapporte qu'aux Etats-Unis les étudiants mâles s'inscrivent de plus en plus nombreux dans les écoles d'infirmières.

On en comptait 455 en 1948; en janvier, 1949, 123 écoles admettaient des étudiants mâles.

Les services d'hygiène publique semblent s'intéresser davantage à ce groupe. Un article, publié dans le même numéro et intitulé "Men Nurses in Public Health Nursing" écrit par l'un d'eux, présente le travail qui peut être fait par cette catégorie d'infirmiers.

AU SERVICE DES RHUMATISANTS

Une clinique externe, un centre de diagnostic, de traitement, d'hospitalisation, et une clinique mobile semblent l'installation d'essai d'un centre de traitement pour rhumatisants de toute la province de la Colombie-Britannique. Les malades qui se présenteront à ce centre seront dirigés, après examen, à leur médecin de famille ou demeureront au centre pour traitement.

Les traitements sont accessibles à tous, même à ceux qui ne sont pas indigents et, s'il y a lieu d'avoir des médicaments, on peut se les procurer gratuitement au dispensaire du Vancouver General Hospital.

Trois masseuses (physiothérapistes) sont employées au centre; les malades qui ne peuvent s'y rendre sont traités à domicile. On fait une campagne éducative intense. —*Welfare*, juillet 1949

EXPANSION DES SERVICES DE SANTÉ

Toute la population du Canada peut bénéficier de la pension de vieillesse. Les territoires du Yukon participeront à ce privilège pour la première fois. Toutes les provinces, sauf Terre-Neuve, ont avisé le gouvernement fédéral cette année qu'elles étaient en faveur d'une augmentation de la pension de vieillesse, laquelle sera désormais de $40.—*Welfare*, juillet 1949.

LA LUTTE ANTI-TUBERCULEUSE ET LES INDIENS

Le Service de Santé du Département des Indiens prenait charge d'un ancien hôpital militaire à Miller Bay. Les tribulations du personnel ont été nombreuses—soigner les Indiens comme au temps de la colonie n'était pas une tâche facile. L'hôpital compte 160 lits déjà tous occupés.—*Canadian Association Tuberculosis Bulletin*, juillet 1949.

LA DIXIÈME PROVINCE

Les services de santé de Terre-Neuve sont décrits par le Dr James McGrath, assistant-directeur des Services de Santé du Ministère de la Santé à Terre-Neuve. Il y a 1,500 établissements dispersés sur les côtes d'une longueur de 6,000 milles. A cause de la distance, de l'isolement, de la faible densité de la population, et du manque de voies de transport, il est difficile de donner aux habitants les soins que réclame leur santé au temps quand ils en ont besoin. Les services de santé semblent plutôt se concentrer dans la capitale. A St. John's, il y a un grand hôpital général, un sanatorium pour tuberculeux, un hôpital pour malades mentaux, et deux hôpitaux privés appartenant à des Soeurs de la Miséricorde et à l'Armée du Salut.

Dans 14 districts on trouve une organisation qui, moyennant une contribution, assure aux membres les soins en maladie et l'hospitalisation. Ces organisations constituent la charpente des services de santé dans cette province. Le père de famille paie une contribution annuelle de $10 et lui et tous les membres de sa famille reçoivent les soins médicaux et l'hospitalisation au besoin.

Le service des infirmières des districts, organisé dans le but de donner à la population isolée les services d'une infirmière et, jusqu'à un certain point, des soins médicaux, a été des plus affecté par la pénurie d'infirmières. La tuberculose est un des plus grands problèmes des services de santé. Tous les citoyens de Terre-Neuve peuvent bénéficier gratuitement des services offerts pour la lutte antituberculeuse.

La vaccination contre la coqueluche et la diphtérie et les traitements des maladies vénériennes sont aussi gratuits. Les patients qui négligent ou refusent de se faire soigner sont suivi de près et même il y a une loi pouvant les contraindre à se faire traiter. Toutefois elle n'est appliquée que lorsque tous les autres moyens de persuasion ont échoué.

EN ALLANT DE L'AVANT

Un cours sur Relations Humaines fut suivi par un groupe d'infirmières hygiénistes, surveillantes, et institutrices. La discussion porta surtout sur les motifs qui font agir les personnes, les rapports de l'individu avec le groupe où il vit ou travaille, et sur la façon de procéder lors d'une entrevue. Mme B. A. Bennett discuta des problèmes des relations entre humains et de la publicité faite pour favoriser le recrutement des élèves infirmières. Elle rapporta qu'il y a 5,000 étudiantes de plus cette année et que cette augmentation permettrait à la profession de faire parmi ces

élèves un choix judicieux.—*Nursing Mirror*, le 6 août 1949.

QUOI DE NEUF EN AUSTRALIE?

On vient de fonder en Australie un Collège de Nursing à Victoria. Ce collège est fédéral. Il est administré par un conseil de 20 membres, dont un nombre égal de représentants pour chacun des Etats et d'un président indépendant.

Les buts du collège sont: de constituer une organisation nationale; de donner des cours post-scolaires aux hospitalières, aux institutrices et aux administrateurs d'hôpitaux; que les diplômes donnés par le collège soient reconnus dans le monde entier.—*The Australasian Nurses' Journal*, mai 1949.

QUELQUES LIVRES NOUVEAUX

Deux nouveaux livres publiés ont été reçus au secrétariat de l'A.I.C. L'une a pour titre "Safer Ways in Nursing to Protect against Tuberculosis," préparé conjointement par le Service Consultatif en Tuberculose de la National League of Nursing Education, National Organization for Public Health Nursing, et l'Association Nationale Antituberculeuse des E.-U. C'est un traité de 107 pages donnant les principes du nursing chez les tuberculeux et leur application. C'est un petit livre pratique, de nature à rendre de grands services.

L'autre, intitulé "The Instructional Plan for Basic Tuberculosis Nursing," a pour auteur le Sous-comité du Nursing en Tuberculose du Comité des Etudes. Il a été préparé comme supplément au livre bien connu—"The Curriculum Guide for Schools of Nursing." On y trouve le programme de ce que l'on doit enseigner à l'élève durant son cours de base sur la tuberculose, une bibliographie se rapportant à tous les problèmes de la tuberculose. Ce manuel de 58 pages sera apprécié des institutrices.

Why do We Yawn?

WALDEMAR SCHWEISCHEIMER, M.D.

Average reading time — 5 min. 36 sec.

A young student entered on his examination in a state of mental and physical fitness and overflowing with knowledge. An intricate problem involved a discussion between the examining professor and the student. Suddenly, just as the professor was explaining an important point, the student unconsciously raised his hand to his mouth and—yawned. The professor was astonished and angry. "Are you tired? Did you work too long last night?" he asked the blushing young man. But the student assured him that he was perfectly rested and felt well and efficient. And he was!

Yawning is an unconscious process. The mouth opens, the glottis opens wide, and air is inhaled deeply, followed by a short exhalation—both usually accompanied by peculiar sounds. Simultaneously, other muscles are moved to further the inhalation—the arms are stretched and the chest expanded.

The cause of these combined movements is a sudden hunger for air. For this reason, one is most likely to yawn when fatigued—when the oxygen content of the blood or the blood content of the brain is reduced. The tissues send up a demand for more oxygen by way of the breathing centre in the upper part of the spinal cord and the nervous system. This is supplied by deep breathing and may be accompanied by yawning.

One of the first vital impulses of a baby is to yawn deeply, tightly clenching his tiny fists at the same time. A grown-up, who has been sitting at his desk for some hours, will yawn deeply and stretch his arms when rising from the desk. His whole body is vigorously stretched and extended.

All these motions serve the same purpose: to convey more oxygen to the body. Yawning is a practice in which we all indulge, though sometimes mixed with a feeling of embarrassment. It is, in fact, a useful exercise—just like stretching—for any body which has been insufficiently active. Yawning often is the sign of an increased need for sleep. Many persons feel the urge to yawn after they have spent some time in crowded or bady ventilated rooms.

Society considers open yawning a sign of bad manners or lack of self-control. On the stage or screen, an actor who has the inten-

(*Please turn to page 862*)

Student Nurses

Rheumatic Fever — Scourge of Early Childhood

Olive B. Warren

Average reading time — 4 min. 24 sec.

Dr. Wm. Osler once said, "Rheumatic fever kills at long range." Indeed, so long is its range that the first, and perhaps only attack usually occurs between the ages of seven and ten years. Its long lasting effects are due chiefly to the complication of rheumatic carditis, an inflammation of the heart which occurs as part of, or follows the disease. Rheumatic fever is seldom fatal, having a mortality rate of less than 3 per cent, but in all general hospitals simple rheumatic carditis fills more of the medical beds than any other lesion. Fully nine-tenths of all the heart disease which occurs in the first forty years of life is rheumatic in origin and, in nearly three-fifths of the cases, the cardiac disease had its onset before fifteen years of age. It is rare in the first years of life and has its greatest incidence in the seven to ten-year-old group. It is said to be present in 2 per cent of all school children, its distribution between the sexes being practically equal.

Let us then, with these startling facts in mind, review this disease as to its probable cause, its symptoms, complications, the therapeutic measures used in treating it and, more important, perhaps, the prophylactic measures which will decrease the incidence of rheumatic fever in our country and the world.

There is a great deal of controversy as to the cause of rheumatic fever. However, it is generally agreed that the disease originates from some focal infection in the upper respiratory tract, a variety of streptococcus probably being the offending organism. As a result of chronic infection or repeated acute infections, the body becomes sensitized to the organism. Continued or repeated infection, after sensitization leads to an allergic response, the severity of the response depending upon the degree of sensitization.

This allergic response of a sensitized body gives rise to a group of symptoms which permit the diagnosis of rheumatic fever. The symptoms vary greatly in nature and degree and not infrequently are so vague and slight as to pass unnoticed. These weak harbingers of a serious condition are the so-called "growing pains" which are dismissed lightly by many parents as a normal phase of childhood. Usually the joint pains are of a "flitting" nature—for example, the child comes homes from school complaining of a stiff neck. He is put to bed at the usual time, is somewhat restless throughout the night, but feels better in the morning and is sent to school as usual. During the next week, the child may complain of a sore ankle or elbow, but the soreness and swelling, if this is present, disappears so quickly without treatment and the symptoms seem so unrelated—from stiff neck to sore ankle—that the mother is lulled into a false sense of security. Actually, these harmless pains are often accompanied or followed by a marked degree of heart damage.

Miss Warren prepared this material during her period as a student nurse at the Sarnia (Ont.) General Hospital.

While this is the picture in many cases, others are much more acute, often following an attack of tonsillitis or exposure to cold. In these, the onset is usually sudden with chilliness, fever, and inflammation of the joints as the chief symptoms.

Knowing that rheumatic carditis is the most dreaded complication of rheumatic fever, we conclude that the primary point in treatment and nursing care is to prevent damage to the heart. This can only be accomplished if the child is treated early and adequately. Continuous and absolute bed rest is essential, in addition to plenty of sleep and a minimum of exertion. Many drugs have been tried, but the salicylates seem to have proven most effective and have gained a name for themselves as specifics in the treatment of rheumatic conditions. Treatment should continue until two or three weeks after the disappearance of all symptoms as any undue exertion at this period will damage the heart. Recurrences are fairly common throughout childhood but usually cease at puberty. The familial incidence of rheumatic fever would lead us to suspect heredity as a factor, but environment favorable to multiple incidence may account for this. It is most common in the temperate zones during the season when there are the greatest daily fluctuations in temperature. Some other of its complications are chorea or St. Vitus Dance and secondary anemia.

This disease, with its attendant evils, is a serious enough menace to young children to rouse every adult to action against it. The chief prophylactic measures are: (1) removal of focal infections such as diseased tonsils and adenoids very early, before the body becomes sensitized; (2) adequate rest and diet; (3) general healthful living conditions, avoiding exposure to cold and dampness, overcrowding and other things that favor the occurrence of upper respiratory infections. When the general public has been educated to recognize the importance of early diagnosis and treatment, we shall have passed one milestone on the road. When our social security plans can ensure for every child a healthful environment and adequate diet, we shall have reached our goal—the eradication of another of the scourges of early childhood.

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Ontario

The following are recent staff changes with the Ontario Public Health Nursing Service:

Appointments: *Helen Fasken* (Hamilton General Hospital; University of Western Ontario certificate course; University of Toronto advanced course in administration and supervision) as public health nursing supervisor, Wellington County health unit; *Miriam MacDonald* (Toronto Western Hosp. and U. of T. cert. course and advanced course in admin. and supervision) as public health nursing supervisor, Windsor Board of Health; *Jennette Gillespie* (B.N., McGill University) as public health nursing supervisor, Halton County health unit (*Margaret Outtier* acted during Miss Gillespie's absence).

Mrs. J. P. LeFlair (U. of T. diploma course) as senior public health nurse, New Toronto, succeeding *Gertrude Reid* (Peterborough Civic Hosp. and U. of T. cert. course) who has retired; *Gertrude Purcell* (Toronto Gen. Hosp.; U. of W. O. cert. course and U. of T. advanced course in admin. and supervision) as senior public health nurse, East York-Leaside health unit—also appointed to this unit: *Marlene Smith* (Women's College Hosp., Toronto, and U. of T. cert. course), *Ethel Irwin* (T.G.H. and U. of T. cert. course), and *June Schaefer* (Toronto East. Gen. Hosp.

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and U. of T. cert. course); *Carrie Genik* (Royal Alexandra Hosp., Edmonton, and U. of T. cert. course and advanced course in admin. and supervision) as acting senior public health nurse, Northumberland and Durham health unit—also appointed to this unit: *Lois Costello* (B.Sc.N., U. of W.O.), *Mavis Elliott* (Victoria Hosp., London, and U. of W.O. cert. course), and *Kathrine Ferguson* (Ottawa Civic Hosp. and U. of T. cert. course).

Winnifred Walker (T.W.H. and U. of T. cert. course), formerly public health nursing supervisor, Guelph Board of Health, as public health nurse, Pickering Township board of health; *Norah Gibbon* (St. Bartholomew's Hosp., London, Eng., and Royal College of Nursing) and *Agnes Napier* (B.Sc.N., University of Ottawa) St. Catharines-Lincoln health unit; *Jean Falconer* (Kitchener-Waterloo Hosp. and U. of W.O. cert. course) Galt board of health; *Mary Poulin* (U. of Ottawa undergraduate and grad. nursing courses), formerly with Ottawa board of health, to Ottawa secondary school health service; *Elsie Crawford* (Peterborough Civic Hosp. and U. of T. cert. course) Peterborough board of health; *Irma Ternan* (Guelph Gen. Hosp. and U. of T. cert. course) Bruce County health unit; *Esthel Poirier* (Halifax Infirmary and McGill U. cert. course) Porcupine health unit; *Edna Thomas* (Health visitor) as public health nurse with Fort Frances board of health; *Frances Downham* (Royal Victoria Hosp., Montreal, B.Sc., U. of W.O.) Kitchener board of health; *Jean Moynan* (B.N.Sc., Queen's University), formerly with Carleton health unit, to Prince Edward County health unit; *Gertrude Dickey* (Moncton Hospital, N.B., and McGill U. public health course) Elgin-St. Thomas health unit.

Resignations: *Susannah Childerhose* as senior public health nurse, Woodstock board of health; *Jean (Scrimgeour) Wilson* as senior public health nurse, East York-Leaside health unit; *Margaret McEachern* from Wellington County health unit; *Lenna Fraser* from Kent County health unit; *Ruth Austin* and *Bernice Seeds* from Northumberland and Durham health unit; *Rosella Cunningham* from Northumberland and Durham health unit, *Jean Rhoten* from Pickering Township, and *Margaret Turner* as senior public health nurse in Wentworth County, all to take public health nursing admin. and supervision course at U. of T.

Trends in Poliomyelitis

The current flare-up of poliomyelitis in several parts of the country makes timely a consideration of certain aspects of the situation that may be generally overlooked. While the number of reported cases has been higher in the past decade than in any earlier comparable period, there is reason to believe that some of the increase is more apparent than real.

In the absence of preventive measures, some increase would be expected because of the growth of our child population among whom the disease is concentrated. Since 1940 the population under age 15 has risen more than 20 per cent. Moreover, it is likely that the serious housing shortage and the consequent crowded living conditions have been favorable to the spread of the disease. Another factor is the diminishing degree of isolation of the rural population. With the increased mobility of our people, it is not surprising that poliomyelitis is reported with increasing frequency in areas that apparently were little affected previously.

In contrast with these factors, which make for a true increase in the incidence of the disease, there are other factors which reflect only the improvement in the diagnosis and reporting of poliomyelitis. Reporting practices vary somewhat in different parts of the country, although there is increasing uniformity in this respect. Non-paralytic cases are under-reported everywhere and in many places are not accounted for at all. Even more important, however, is the fact that mild cases generally go unrecognized in some parts of the country and this situation is widespread in non-epidemic years. It is likely, therefore, that the number of persons affected by the disease is much greater than appears in the statistics. Indeed, according to many experts, the cases which are recognized and reported are only a small fraction of the total actually occurring. Fortunately, many children experience subclinical attacks which, although unrecorded, serve to build up immunity to the disease.

Poliomyelitis is concentrated at the ages

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Applications are invited from suitably qualified candidates for the posts of **Ward Sisters** and **Staff Nurses in Mental Diseases** at the Tara Branch of the Johannesburg Hospital, at the salary scale £225x15—240x20—320—5 yrs.—360—5 yrs. 400 and £180x15—225 respectively plus free board, quarters, laundry and uniform in each case or a living-out allowance of £120 per annum in lieu of board and quarters.

The qualifications required are as follows:

Ward Sister: Medical and Surgical Nursing Certificate. Certificate for Mental disorders.

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Persons will have to register as nurses with the *South African Nursing Council, S.A. Mutual Buildings, Church Square, Pretoria,* before they can be appointed and for this purpose certified copies of their certificates should accompany their applications.

In both cases, preference shall be given to applicants who have had experience in the nursing of neuro-psychiatric cases.

The possession of double qualifications entitles holder to non-pensionable allowance of £24 per annum, while employed at Tara Hospital.

Forms of application may be obtained from the *Office of the High Commissioner for the Union of South Africa, 15 Sussex Street, Ottawa, Ontario.* Full particulars should be given as to the age, professional, academic experience, and conjugal status of the applicant and should further indicate the earliest date upon which duties can be assumed. Copies only of recent testimonials to be attached.

Successful candidates will be required to submit to a medical examination at the Johannesburg Hospital.

In addition to salary, the successful applicants will receive leave privileges, rail concession, and cost of living allowance.

under 15, with the peak rate in the preschool ages. There is some indication, however, of a recent shift in the age distribution of the disease toward the higher childhood ages and of an increase in the proportion of young adults affected. Caution must be exercised in interpreting the data, however, because they are influenced by changes in the age composition of the population. Moreover, there is the possibility that the increased number of mild cases reported affects these age comparisons since the diagnosis of such cases is more difficult in infants and young children than in older children. On the other hand, the unusually large proportion of cases at ages past 15 in some recent outbreaks may, in part, reflect the accelerated movement of young people from rural to industrial areas during the war period.

In the face of the increase in the reported incidence of poliomyelitis, the statistics of mortality from the disease are distinctly reassuring. The general trend of the death rate has been downward over the years.

The long-term decline in the death rate from poliomyelitis is largely the result of the reduction in mortality at ages under 10, particularly among girls. The trend at ages over 10 is somewhat irregular, but there is some indication of a rise, especially among boys. The reasons for this difference in trends, according to age and sex, are not clear but, in part, it may reflect some change in the average age of exposure to the disease.

Despite the widespread public interest in poliomyelitis, it remains a relatively uncommon disease, whether measured in terms of cases or deaths. Even the epidemic years show comparatively limited areas seriously affected and, in any specific area, outbreaks usually occur many years apart. In 1949, the cases reported include a large proportion with the mild or non-paralytic form.

— *Statistical Bulletin, M.L.I.C.*

There is time in the twenty-four hours for all that there is to do if but one thing is done at a time, but there is not time in the whole year for what is to be done if two things are done at one time.—CHESTERFIELD

Yawning

(*Continued from page 856*)

tion of going to bed often intimates this intention by an elaborate yawn. Or, in an aside to the audience, the hero in a play will show his boredom at some lengthy tirade, also by a yawn.

And yet, yawning is not always connected with boredom. A person may yawn when he is moved by alert attention, by intense interest, or a kind of breathless excitement.

Take a "card fiend," for instance. He knows that the next trick will decide the outcome of the game. His every nerve is strained but he tries to hide his emotion. Suddenly he yawns. Most certainly he is not bored, and neither is he tired. However, behind his mask of indifference, his heart is beating quicker, the internal oxidation processes are hastened, but he suppresses his desire to inhale deeply or to shout with joy; so the lack of oxygen, resulting from his quickened blood circulation, has to be supplied by yawning.

Another example—A rather bashful lover has finally managed to be alone with his girl under a starlit sky. The young lady is eagerly awaiting his declaration. The young man is too bashful to speak the words he has in mind. He puts off his proposal from one minute to the other. Suddenly the girl yawns.

The boy is both dismayed and shocked. He has the terrible feeling that his presence is boring to the young lady. But just the contrary is true. The agony of waiting and the feeling of an impending vital decision have moved the girl to a degree she would like to hide. She feels like breathing deeply, she suppresses this longing, and the lack of oxygen in the blood gives rise to the shocking yawn which is by no means the result of acute boredom but reflects the most extreme emotion and attention.

In certain cases of illness repeated yawning is a symptom of the disease. In particular, diseases of the blood vessels or heart are sometimes connected with a shortage of oxygen in the blood, and thus may cause yawning.

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—*South African Nursing Journal, March, 1949.*

Book Reviews

Pediatric Nursing, by Gladys S. Benz, R.N., B.S. 638 pages. Published by The C. V. Mosby Co., St. Louis. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 1948. Illustrated. Price $4.40.

Reviewed by Maude Dolphin, Head Nurse, Pediatric Dept., Royal Victoria Hospital, Montreal.

In her preface, Miss Benz states: "It is hoped that this volume will open the door to a broader understanding of the basic principles of child care and will increase her (the nurse's) interest in the community agencies and institutions which influence the child." This book achieves that purpose in a simple and forceful manner. The child is studied in sickness and health in relation to his family, the community, and the hospital. His needs, both physical and mental, are considered.

The book is divided into units—well planned and complete in themselves. At the end of each unit is an excellent reference list for the student whose interest has been aroused in any specific subject. This text constantly encourages further study. In her plan, the author starts with the development of pediatrics, moves on to the newborn infant, its care, feeding, and illnesses, then follows the growth and development of the normal child. With Unit IV, the author leaves the normal child to go into general nursing care, then the nursing care of specific diseases. Her last unit—The Child in the Community—presents the study of modern facilities for child care, such as hospitals, educational units, juvenile courts.

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For a student who is looking for scientific data the book would be inadequate, but for the student nurse there is sufficient to give an intelligent basis for nursing care. This book is a starting point for students: the essential scientific facts are present, the details of nursing care are well outlined and, above all, the completeness of the understanding of the child and his needs gives the reader a solid foundation for a course in pediatrics. The author creates that attitude towards children which is so essential for a pediatric nurse. She also emphasizes the importance of the parent as a key to the child's behavior, health, and habits.

This book, invaluable as it may be to the student, may also advisedly be read by the specialist. It acts in a sense as a renewal of the fundamental simplicity of the understanding of the child that may have been partially obscured by an accumulation of scientific facts.

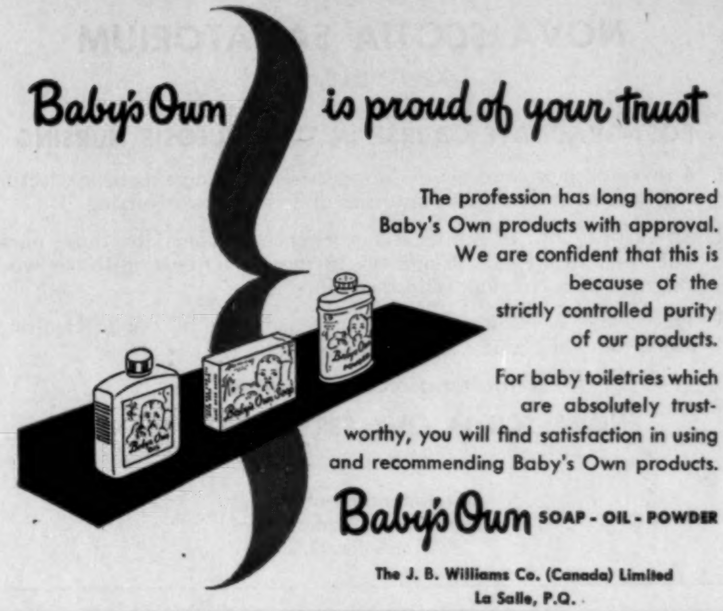
Rheumatic Fever — Nursing Care in Pictures, by Sabra S. Sadler, R.N., B.S. 151 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1949. 204 illustrations. Price $3.75.

Reviewed by Sr. M. Felicitas, Director of Nursing, St. Mary's Hospital, Montreal.

Although Mrs. Sadler states in her preface that this book is written and illustrated primarily for parents, it should be very valuable to nurses, student or graduate, who wish to increase their knowledge of rheumatic fever. The 204 illustrations (most of them actual photographs) are especially prepared as a visual aid to "cover fully the practical application of the written material and enable one to become familiar with the suggested procedures."

The introduction, written by Reno R. Porter, M.D., takes up the first thirteen pages and is an admirable summary, in simple language, of the cause, pathology, manifestations, course, prognosis, diagnosis, and treatment of rheumatic fever. The remainder of the book deals with several of these aspects in more detail, stressing particularly the nursing care of the patient. This is extremely well done. A glance through the contents reveals such items as: "Understanding the visit to your doctor," "preparation for bed rest," "personal care of the patient," etc., with sub-headings such as "care of the skin," "polyarthritis," "back rubs," "grooming the patient," "oral hygiene," etc.

Throughout the book there is meticulous attention to every detail which has any bearing on the disease or its nursing care.



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Nursing the patient in his own home is uppermost in the author's mind, and devices for improvised equipment are liberally inserted and thoroughly explained. Any nurse finding herself in such a situation for the first time would call down blessings on the author for this guidance and assistance.

Right attitudes to ward rheumatic fever are stressed throughout the book, including education of the patient and his family to the acceptance of restrictions in physical exercise according to the physician's advice. The final chapter on Returning to Normal emphasizes the continuation of good health habits, regular physical examinations, avoidance of respiratory infections, and necessary adjustments to employment, "with the aim of keeping the individual a happy, useful, and healthy citizen."

This book, with its attractive cover and plastic-ring binding, is a valuable addition to any nurse's library—individual or general. It should be particularly appreciated by public health nurses who would immediately recognize the worth of such a work in the home care of rheumatic fever patients.

Living Anatomy — A Photographic Atlas of Muscles in Action and Surface Contours, by R. D. Lockhart, M.D., Ch.M. 71 pages. Published by Faber & Faber Ltd., London, Eng. Canadian agents: British Book Service (Canada) Ltd., 263 Adelaide St. W., Toronto 1. Price $3.75.

Reviewed by Jessie Cook, Science Instructor, Royal Victoria Hospital, Montreal.

In the words of the author, "The purpose of this book is to awaken the students' interest in studying, literally at first-hand, muscles in action in the human body."

This little volume of only seventy-one pages is a series of excellent photographs of living male and female subjects, showing clear outlines of many groups of muscles of the arms, legs, abdomen, etc. The majority of the pictures show the muscles acting to overcome definite resistance to their movements, while indicators aid in recognition of muscles, ligaments, tendons, and bony prominences.

Several pictures demonstrate a simple method to show the flow of venous blood and valves in the arm while a number of others point out various structures of the eye and lids.

Finally, photographs, along with brief written descriptions, call attention to differences in body contour in male and female subjects and several views of the female breast are shown.

While this book may not prove of much

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practical value as a textbook for the student nurse, it should serve as a useful guide to teachers of anatomy, as well as to medical students and other advanced students of the living human body.

An Evaluation of Selected Schools of Nursing, with respect to certain educational objectives, by Helen Nahm. 96 pages. Published for the American Psychological Association by Stanford University Press, Stanford, Calif. 1948. Price (in U.S.A.) $2.00.

Dr. Nahm based her study on some of the criteria which are frequently overlooked in an analysis of how efficiently nursing education programs are functioning. She selected six educational objectives considered to be "of primary importance to the profession in a democratic society." These did not analyze how well a nurse could perform any given nursing technique nor how proficient she was on examinations. Rather, the author's purpose was to endeavor to discover how well adjusted groups of students were to their chosen profession, the degree of satisfaction they manifested in their work, the range of their cultural, social, economic, and recreational activities and interests. Twelve schools of nursing in Minnesota provided the material for the study, the 428 senior students being the chosen group. Reliable tests and questionnaires were administered to this group.

The findings provide very interesting reading. For example — "Scores on the Nursing Satisfaction Scale indicated that 24 per cent of the students were enthusiastic about nursing, 61.6 liked it, 13 per cent were indifferent, and 1.4 disliked it." There were indications of various levels of dissatisfaction. In summing up all her various findings, Dr. Nahm indicates that a number of changes need to be made in schools of nursing in order to produce the best balanced type of nurse. "Shorter hours of work are needed, as well as better health care of students, and improved social and recreational facilities."

The most important factor, however, that came out of the study was the need for greater attention to the "preparation of faculty members." Dr. Nahm says, "It is of little use to talk to students in nursing about the importance of democracy so long as the total environment in which they are educated is dominated by an authoritarian philosophy. It is of little avail to teach mental hygiene principles in the classroom so long as faculty members violate those principles in their day-by-day relationship with students and

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others. Better preparation of faculty members in these areas would do much to improve the human relationships in hospitals and schools of nursing.

Directors of nursing will find that this study makes interesting and profitable reading.

The Story of the Growth of Nursing, as an Art, a Vocation, and a Profession, by Agnes E. Pavey, S.R.N. 426 pages. Published by Faber & Faber Ltd., London, Eng. Canadian agents: British Book Service (Canada) Ltd., 263 Adelaide St. W., Toronto 1. 2nd Ed. 1947. Price $3.75.

More than just a formal history of the development of nursing, Miss Pavey has sought to determine, by the course of events in world history, why nursing has progressed as it has. She has introduced many data not commonly incorporated in a text of this kind. She shows how nursing developed first as an art, then a vocation, and how today it justifiably takes its place as a profession, combining all three aspects in a harmonious whole. The story makes interesting and instructive reading, the emphasis here being placed to a greater degree on developments in the British scene. It is interesting to compare it with other texts commonly used in this country.

This is not a revised edition, being a reprinting of the 1944 edition. Thus, the recent world-wide developments are omitted. There are no illustrations which would have added to the appearance of the pages. The frequent quotations from source material provide variety but the actual physical reading is not as easy as in some other books. The information is worth the effort.

Missing Person

The Canadian Red Cross Society is endeavoring to trace **Mrs. Dyson Carter,** *née* **Lottie Breckman,** a nurse who lived in Winnipeg at one time, later moving to Toronto. Any information regarding her whereabouts would be gratefully received by the National Enquiry Bureau of the Society at *95 Wellesley St., Toronto 5.*

USED COPIES WANTED

The National Office of the Canadian Nurses' Association has received many requests for copies of the **Proposed Curriculum for Schools of Nursing in Canada** and of the **Supplement** to the Curriculum for Schools of Nursing in Canada.

The stock of these is completely exhausted. Until such time as an additional supply is available, National Office is anxious to procure used copies. Depending on their condition, copies will be paid for at ***25-50 cents*** each. Send the copies you are not using to: *Canadian Nurses' Association, Suite 401, 1411 Crescent St., Montreal 25, Que.*

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Rats comprise more than one-third of the earth's population of mammals, thus being the most numerous single species. There have been 554 forms described.

M.L.I.C. Nursing Service

Madeleine De Santis (St. Vincent de Paul Hospital, Sherbrooke) has been appointed to the Montreal nursing staff. *Brigitte Beaudet* has been transferred from Montreal to Quebec City. *Madeleine Bulteau*, who has been working on the Quebec City staff, has resigned to be married.

Victorian Order of Nurses

The following are recent staff changes of the Victorian Order of Nurses for Canada:

Appointments — Calgary: *Mary Elias* (University of Alberta School of Nursing and U. of A. public health course). Chatham: *Elsie Jackson* (Public Gen. Hosp., Chatham). Guelph: *Agnes M. Foy* (St. Joseph's Hosp., Guelph). Lachine: *Germaine D'Allaire* (Ste. Justine Hosp., Montreal). Montreal: *Frances Hicks* (Royal Victoria Hosp., Montreal, and B.Sc., University of Western Ontario). Oshawa: *Dorothy Weissgerber* (Women's College Hosp., Toronto, and University of Toronto public health course). Ottawa: *Marjorie Greene* (Kingston Gen. Hosp.). Port Arthur: *Margery Spencer* (Port Arthur Gen. Hosp.). Surrey: *Joy Stewart* (Toronto Gen. Hosp.). Toronto: *Mary McCulloch* (T.G.H. and U. of T. p.h.n. course). Waterloo: *Agnes Buckingham* (Kitchener-Waterloo Hosp.).

Re-appointments — Carleton Place: *Dorothea Atkinson* as nurse in charge. Cobalt: *Thérèse Lynch* as nurse in charge. Galt: *Joyce Curran*. Port Arthur: *Marjorie McIntosh* as nurse in charge. Sackville: *Margaret J. Nicholson* as nurse in charge. Victoria: *Mildred Williams*. Waterloo: *Helen (Thompson) Seibert* as nurse in charge.

Leave of Absence — *Margaret Joyce* from Smiths Falls for further study at McGill University; *Ellen Pocock* from Gravenhurst to work in England; *Winnifred Tredaway* from Victoria.

Transfers — *Vivian Adair* from Montreal to Ottawa; *Mary Brebner* from Edmonton to Gravenhurst as nurse in charge; *Mary Joan Clegg, B.Sc.*, from Windsor (Ont.) to London; *Mary Cochrane* from Halifax to Amherst; *Marianne Coleman* from Galt to York Township; *Marion Hellyer* from Prince Albert to Saskatoon; *Valda Howard* from Chatham (Ont.) to Lindsay as nurse in charge; *Joan McCann* from Porcupine to Leamington as nurse in charge; *Irene Sheasby* from Fort William to Brantford; *Vida Tanner* from Halifax to Amherst as nurse in charge.

Resignations — *Sarah Bayard* from Victoria, *Gladys Bowman* from Port Arthur, *Helen (Voss) Gulliver* from Leamington, *Marjorie Hunter* from Amherst, *Marian Law* from Welland, *Hazel Lindsay* from Toronto, *Jane MacIntyre* from Ottawa, *Jessie MacKeil* from Moncton, *Verna McCrory* from Medicine Hat—marriage. *Patricia Marks* from St. Catharines, *Minnie Samuels* from Liverpool, *Helen Smith* from Calgary, *Isla Tuck* from Surrey—to take up other work. *Jean (Howey) Brook* from Winnipeg, *Beverly Colewell* from Kingston, *Muriel Laturney* from Peterborough for further study at U. of T., *Mary Reynolds* from Toronto, and *Barbara Tunis* from Montreal.

The following nurses have been awarded scholarships of $750 from the V.O.N. and are at present enrolled in public health nursing courses in various universities in Canada:

University of Alberta: *Vivian Harding* (U. of A., Edmonton).

University of British Columbia: *Marion Boyle* (Vancouver Gen. Hosp.), *Elizabeth Caplette* (V.G.H.), *Eveleen Dunne* (St. Eugene Hosp., Cranbrook), *Roberta Nixon* (Calgary Gen. Hosp.), *Amy Parliament* (Grace Hosp., Winnipeg), *Joan Piddington* (Royal Jubilee Hosp., Victoria), *Doreen Pope* (V.G.H.).

University of Manitoba: *Jean Allen* (T.G.H.), *Lillian Frank* (St. Paul's Hosp., Saskatoon), *Genevieve MacLean* (Port Arthur Gen. Hosp.).

McGill University: *Kay Brown* (St. Mary's Hosp., Montreal), *Joan Chisholm* (Montreal Gen. Hosp.), *Patricia Ann Corbett* (St. Mary's Hosp., Montreal), *Sheila Jamieson* (M.G.H.), *Anna Knecht* (M.G.H.), *Norma McKee* (M.G.H.), *Lorna Tomalty* (M.G.H.), *Stelia Warwick* (Homoeopathic Hosp., Montreal), *Mary Wurtele* (M.G.H.).

University of Montreal: *Sylvaine Cadorette* (Ste. Justine Hosp., Montreal), *Pierrette Daoust* (Notre Dame Hosp., Montreal), *Philomena Fuoco* (St. Joseph Hosp., Lachine), *Laurence Girard* (St. Joseph Hosp., Lachine), *Jeannine Nobert* (Ste. Justine Hosp., Montreal).

Queen's University: *Marion Vine* (Kingston Gen. Hosp.).

University of Toronto: *Mary DeGiacomo* (St. Joseph's Hosp., Port Arthur), *Leah Enslen* (Medicine Hat Gen. Hosp.), *Bernice Gibson* (T.G.H.), *Ilean Gibson* (Hamilton Gen. Hosp.), *Minola Gould* (Victoria Hosp., Renfrew), *Glenna Kendall* (Toronto Western Hosp.), *Helen M. Kent* (Women's College Hosp., Toronto), *Grace Latham* (St. Mary's Hosp., Timmins), *Katherine McDonald* (St.

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Mountain Sanatorium,
Hamilton, Ontario.

Joseph's Hosp., London), *Mary Prang* (Winnipeg Gen. Hosp.), *Mary Sehl* (St. Mary's Hosp., Kitchener), *Shelah Thompson* (Ottawa Civic Hosp.), *Vivian Walker* (T.W.H.).

UNIVERSITY OF WESTERN ONTARIO: *Virginia Blackhurst* (Victoria Hosp., London), *Agnes Cree* (Victoria Hosp., London), *Jean Haynes* (Victoria Hosp., London), *Irene Jackson* (T.W.H.), *Winnifred James* (Victoria Hosp., London), *Margaret Kenney* (St. Joseph's Hosp., London), *Mary Martin* (Victoria Hosp., London), *Jean Rollo* (Victoria Hosp., London), *Helen Turnbull* (T.G.H.), *Eleanore Vance* (Victoria Hosp., London), *Phyllis Wightman* (Victoria Hosp., London).

News Notes

ALBERTA

PEACE RIVER

Mrs. W. G. Clarke, matron of the Municipal Hospital for the past five years, has resigned. She will be succeeded by Edna Daniel, a member of the staff since the beginning of the year. The former matron has accepted a position with the Winnipeg General Hospital of which she is a graduate. She will serve as supervisor of the maternity division which is being opened in a new pavilion built adjacent to the main hospital.

BRITISH COLUMBIA

ESSONDALE

At the recent annual meeting of the B.C. Psychiatric Nurses' Association, held at the Provincial Mental Hospital, the awards for the outstanding psychiatric nurses of the year were made. Mrs. A. Vayle, of Hollywood Sanitarium, won the award for the female nurse, while Mr. H. Collishaw of P.M.H. was the recipient of the male nurse award. A report of Mr. J. Streight, solicitor appointed to further the efforts of the organization to obtain professional recognition of psychiatric nurses by statutes, revealed that satisfactory progress is being made.

MANITOBA

BRANDON

Two Brandon nurses will attend universities in the east for post-graduate studies, having received scholarships awarded by the Association of Graduate Nurses. Luella Cook, of Morden, who graduated from the General Hospital in 1947, having been awarded the prize for general proficiency and the bronze medal for theory, has been supervisor at the hospital since graduation. She will attend the University of Western Ontario to take teaching and supervision in schools of nursing. She will later return to the staff of the teaching department of the school of nursing at the hospital.

Julia Ryfa, a graduate in 1944 of the Mental Hospital in affiliation with the Winnipeg General, having received the Eugenie Baragar medal for general proficiency, has been on the staff of the Mental Hospital in a supervisory capacity. She will take supervision in psychiatric nursing at the McGill School for Graduate Nurses.

NEW BRUNSWICK

SAINT JOHN

Saint John was well represented from both hospitals at the N.B.A.R.N. annual meeting held in September. Gertrude M. Hall, general secretary-treasurer, C.N.A., gave a talk on the I.C.N. Conference in Stockholm which was much enjoyed.

Bessie Seaman, president of the local chapter, has resigned her position as V.O.N. supervisor in the city to become a national office supervisor with the Order in Ottawa. Faye Saunders will replace Miss Seaman.

General Hospital

The Hospital Aid recently entertained in honor of the preliminary class. Beatrice Selfridge is now clinical supervisor, while Ruth Chisholm has taken her place in the O.P.D. Roberta Hanscombe is senior instructor of nurses.

ST. STEPHEN

Twenty-six were present at a regular meeting of St. Stephen Chapter when the resignation of Mrs. H. Laurence, as first vice-president, was regretfully received. It was reported that two boxes were sent overseas. A letter of thanks was read from Dr. Everett for services rendered by the nurses at first aid stations during the St. Croix International Jubilee Celebration. M. Dunbar was appointed delegate to the provincial annual meeting. Several nurses have registered with the Disaster Relief Services Committee for New Brunswick (a branch of the Red Cross) to render voluntary aid in case of disaster. Mmes C. Parks and A. Mallory are to be in charge of a rummage sale and committees were also appointed to arrange for a picnic supper and to revise the present registry rules.

ONTARIO

DISTRICT 1

ST. THOMAS

Quick thinking and trained action in saving a little life was recently recognized at the Memorial Hospital when a medal from the Ontario Electric Employers Association was presented to Mrs. F. W. Nicholls, of Talbotville, a member of the hospital staff. The award was made on behalf of the Accidents Preventive Association for her commendable work last April in applying artificial resuscitation to Margaret Ann Shantz when the child was near death by drowning.

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* Public Health Nursing.
* Administration and Supervision in Public Health Nursing.
Supervision in Psychiatric Nursing.
Supervision in Obstetrical Nursing.
Supervision in Paediatric Nursing.

DISTRICT 4

HAMILTON

It has been announced that Joyce Wichmann, of Port Colborne, has been awarded the Russell T. Kelley Scholarship in nursing. Established in 1947 by Health Minister Kelley, this award provides $300 towards tuition in the five-year nursing course at McMaster University.

DISTRICT 5

MIDLAND

May Hilditch, of Wiarton, superintendent of the Arnprior (Ont.) Hospital for the past four years, now holds a similar position at St. Andrew's Hospital. She succeeds L. E. Thomas, for four years superintendent at the hospital. Miss Thomas has taken a post in Newmarket. Jean Holt also resigned as assistant superintendent and is temporarily succeeded by Catherine King, who has been senior x-ray technician at Kirkland Lake Community Hospital.

Miss Hilditch is a graduate of Fordham Hospital, New York, serving with the United Church of Canada as superintendent of hospitals in the northern and western parts of Canada. For a time she headed the 70-bed hospital at Hearst.

TORONTO

To teach nursing in China, Mary Kilborn recently left Canada via a Java mailboat en route to Chengtu, West China, about 1,500 miles inland through the mountains from Hong Kong. At a time when many people are leaving that country, Miss Kilborn says, "I am excited and I want to go very much; help is badly needed." She will begin a new career undaunted by the uncertainties or not knowing where she will be posted. She was accompanied by her father, Dr. Leslie Kilborn, dean of the medical college at Union University in Chengtu, and his wife, also a doctor.

For the first three months she will go to language school, learn how to drink hot tea from a cup without a handle, and polish up her technique of eating an 8-course meal with chopsticks. After that she will be posted as a teacher in either Chengtu or Chungking hospitals. Sent by the Woman's Missionary Society of the United Church, she will be away for a 3-year term. She has taken an obstetric course and hopes to do practical work as well as teaching.

DISTRICT 7

KINGSTON

Sixty industrial nurses from many parts of Ontario and Quebec were recently welcomed at Queen's University by the principal, Dr. R. C. Wallace. They were present to attend the 3-day institute on industrial nursing. Several talks on the value of this branch of nursing were given by Dr. Wallace and he commended Prof. J. C. Campbell for his work in this department.

Recent additions to the teaching staff of the university's school of nursing include Evelyn Moulton and Margaret Allemang. Miss Moulton, nursing arts instructor at the Ontario Hospital, is on leave of absence to complete her degree at Queen's. She will lecture on methods of teaching in a school of nursing. Miss Allemang is nursing arts instructor at Belleville General Hospital. Holding a bachelor's degree in nursing from the University of Toronto, she will give the course in supervision.

DISTRICT 8

OTTAWA

General Hospital

Srs. Ste. Honorine and Jeanne Cécile are working toward their bachelor in nursing education at Institut Marguerite d'Youville, Montreal. Sr. Charles Arthur has left for the University of Montreal to take a dietetic course.

University School of Nursing

Three years of intense study and practice were climaxed recently when 17 young girls received their pins and were "capped" as graduates of the University of Ottawa School of Nursing. Practical training is obtained at the General Hospital. Clover Hastings, of Jamaica, who gave the address of welcome to the guests, was announced as the winner of the first prize gold medal for O.R. technique. She also won first prize in nursing practice. A. Bambrick was the winner of the Dr. G. A. Campbell scholarship for highest standing in theory and practice of pediatric nursing in the second year. Miss Bambrick also won the $175 Florence Memorial Scholarship for highest average in general proficiency. The $25 Casgrain & Charbonneau Scholarship went to F. Penny, of Halifax, for second highest standing in theory and practice throughout the course. R. Lepage, the class valedictorian, won the scholarship for hospital practice.

Each graduate was presented with her pin by Mrs. N. Chassé, president of the General Hospital Alumnae Association, and Mrs. J. A. Gauthier, treasurer of the hospital Ladies' Auxiliary. Diplomas were presented by Rev. Fr. Rodrigue Normandin, secretary of the university. In his address to the nurses, Rev. Fr. A. W. Hall, of St. Patrick's College, suggested they take their life's theme from Thomas Carlyle who wrote, "Know your work and do it." Dr. A. Powers, secretary of medicine at the General Hospital, spoke in French to the graduates.

G. Jolicoeur and E. Mannion, student nurses, entertained with piano solos.

QUEBEC

MONTREAL

Royal Victoria Hospital

Prior to her retirement as superintendent of nurses, Fanny Munroe was honored at an "At Home" given by the alumnae association,

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An examination for the Registration of Nurses in the Province of Ontario will be held on **November 16, 17 and 18.**

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The Director,
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Parliament Buildings, Toronto 2

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By Lulu K. Wolf, Professor of Nursing, Vanderbilt University School of Nursing. This new nursing textbook deals not only with bedside nursing techniques, but with training the patient for future health. 534 pages. 203 illustrations. 1947. **$5.00.**

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of which at one time she was president. Mrs. F. A. C. Scrimger, the president, presented Miss Munroe with a matched set of English aeroplane luggage on behalf of the organization and spoke of her outstanding contribution to nursing in general and to the training school in particular. Mrs. Scrimger and Miss Munroe received the guests.

SHERBROOKE

Appointments of Jeanne Benoit as assistant superintendent of nurses at Sherbrooke Hospital and Flora Moroney as science instructor with the school of nursing have been announced. Miss Benoit graduated from the Children's Hospital, Halifax, serving with the R.C.A.M.C. 1942-46. She was overseas with No. 12 and No. 17 C.G.H. She has been assistant to the superintendent at Victoria Public Hospital, Fredericton, and, prior to her appointment here, took a course in supervision and administration at University of Toronto School of Nursing. Miss Moroney is a graduate of Montreal General Hospital, holding a public health certificate from McGill School for Graduate Nurses. She has done public health work in the Maritimes and was night supervisor at Alexandra Hospital, Montreal. She also served as health supervisor at her home school and as instructor at Jeffery Hale's Hospital, Quebec City.

SASKATCHEWAN

CANORA

O. Podborski has been appointed superintendent of nurses at the Union Hospital. A graduate of the Royal Alexandra Hospital, Edmonton, in 1943, Miss Podborski worked there until 1946, holding positions as supervisor and instructor. Since then she has been in Alberta and at the hospital at Meadow Lake. She is a post-graduate in hospital administration from McGill School for Graduate Nurses and has done communicable disease work at Alexandra Hospital, Montreal.

NOKOMIS

A "Come and Go" tea was held recently in honor of Tillie Webber, superintendent of the Union Hospital for the past five and a half years. The scene was the home of Mrs. J. I. Jamieson when a large number were present to bid farewell to the guest of honor who has done so much towards the success of the hospital during the building and organizing of that institution. Receiving with the hostess was Mrs. Sotski. Assisting with arrangements were: Mmes Lettner, G. Jamieson, L. McEwen, A. MacFarlane, D. Adam, J. D. Kidd, and Dr. S. M. Williams; Misses Winters, Hughes, Powell, and Helgason. Mrs. Hummel read an appropriate address while Mmes Sotski and W. J. Brown made the presentations—a cup and saucer from the Ladies' Auxiliary and a cup and saucer and a purse of money from Lockwood and Nokomis communities.

Edith Todd, of Port Arthur, succeeds Miss Webber. A graduate of the General Hospital there, she was awarded a scholarship for general proficiency. Post-graduating in pediatrics from the Winnipeg Children's Hospital, for the past three years Miss Todd has been matron of Little Bow Municipal Hospital, Taber, Alta.

SASKATOON

City Hospital

Two graduates of the school of nursing are recipients of awards given for advanced work in nursing in universities in Canada and the U.S.A. Beryl Robinson, of Lashburn, has been awarded a bursary by the provincial government to take a course in teaching and supervision at the University of British Columbia. Joining the staff of her home hospital after graduation, in 1946 she took post-graduate work in pediatrics at Children's Memorial Hospital, Montreal, and, since her return to Saskatoon, has been in charge of the children's ward.

Margaret D. Russell, of Unity, has been granted a fellowship by the W. K. Kellogg Foundation. She will go to the University of Minnesota to take a course in clinical teaching. This fellowship is awarded through the University of Saskatchewan. On completion of their courses, both nurses will return to S.C.H.

Margaret Newsham and Wilma Peterson, both graduates of the University of Saskatchewan School of Nursing, will return to the S.C.H. staff in the near future. They have completed post-graduate studies in Montreal and Boston. Maryann Kennedy has returned to the staff, having taken obstetrical nursing at Margaret Hague Memorial Hospital, Jersey City. Eva Christie leaves shortly to take the same course.

St. Paul's Hospital

Two graduates of the school of nursing have been awarded bursaries, under the program sponsored by the Health Services Planning Commission to improve the quality of instructors in the province. They are Sheila Leeper and Gloria O. Brkich. Miss Leeper, of the 1944 class, will take an 8-month course in administration and nursing education at University of Toronto. Since 1947 she has served as supervisor of a Red Cross nursing outpost at Loon Lake. Miss Brkich, who graduated early this year, will take advanced study in teaching and supervision at St. Louis University School of Nursing, Mo. She has been head nurse of the medical and surgical ward at St. Paul's since February.

YORKTON

At the annual meeting of the General Hospital Alumnae Association, the following officers were elected: President, Mrs. E. Parrott; vice-president, Mrs. C. Peet; secretary, Mrs. M. Campbell; treasurer, Mrs. H. Ellis; social convener, Mrs. W. Westurby; councillors, Mmes W. Sharpe, Darrock, Miss Stushnoe.

L. Long has resigned as assistant matron to take a course in hospital administration at McGill School for Graduate Nurses.

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Operating-Room Supervisor & General Duty Nurses. Apply, stating experience & qualifications, Supt., Queens General Hospital, Liverpool, N.S.

Pediatric Supervisor. Post-graduate course in Pediatrics required. Registration in British Columbia essential. 44-hr. wk. 28 days vacation after 1 yr. service. 1½ days sick leave per mo. accumulative. Basic salary: $202.50. Apply Royal Columbian Hospital, New Westminster, B.C.

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Operating-Room Nurses for large active Operating-Rooms in General Hospital, Winnipeg, Man. 48-hr. wk.; straight shift. Information concerning hours, salaries, etc., will be provided on receipt of application, stating preparation, experience & qualifications of nurse. Apply Supt. of Nurses.

Maternity Nurses—post-graduate training preferred, not required. 48-hr. wk.; straight shift. New Maternity Pavilion opening in near future. Information concerning salaries, sick time, etc., provided after application has been received, giving qualifications, years of experience, etc. Apply Supt of Nurses, General Hospital, Winnipeg, Man.

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Supt. & Asst. Supt. for 60-bed hospital. Apply for particulars to Miss D. Bird, Sec.-Treas., General Hospital, Kenora, Ont.

Supt. of Nurses & Principal of School of Nursing for Royal Alexandra Hospital, Edmonton, Alta. Submit complete statement regarding qualifications & salary expected to Dr. D. R. Easton, Medical Supt.

Instructor (qualified) at once. 100-bed hospital, 45 students. Hospital is 40 miles from Edmonton with good train & bus service. Salary schedule according to experience. 8-hr. day, 5½ day wk. with long week-end once a mo. 1 mo. holiday with pay at end of 1 yr. Apply by wire collect or write, stating salary expected, Supt. of Nurses, Public Hospital, Lamont, Alta.

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Registered Dietitian at once for 50-bed hospital. Salary: $175 per mo. gross. Apply Sec.-Manager, Union Hospital, Rosetown, Sask.

Graduate Dietitian at Ontario Hospitals in Kingston, Whitby, Woodstock. Initial salary: $2,140 per annum plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. at above hospitals.

Registered Nurses for General Staff at Ontario Hospitals in Brockville, Hamilton, Kingston, London, New Toronto, Orillia, St. Thomas, Toronto, Whitby, Woodstock & Toronto Psychiatric Hospital. Initial salary: $1,840 per annum plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. of Nurses at above hospitals.

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Floor Duty Nurse. 8-hr. duty. Salary: $110. Full maintenance & laundry. Blue Cross hospitalization. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

Registered Nurses for General Staff work on Rotation Service. Apply Supt., Shriners' Hospital for Crippled Children, 1529 Cedar Ave., Montreal 25, Que.

Registered Nurses for General Duty for modern 200-bed hospital. Salary: $125 per mo. plus maintenance. Increase of $5.00 after 1st 3 mos. 8-hr. day, 6-day wk. 3 wks. holiday with pay plus statutory holidays. Apply Director of Nursing, County General Hospital, Welland, Ont.

Graduate Nurses for permanent General Duty in 500-bed hospital. Salary: $175 per mo. with annual increments of $7.50 per mo. for 4 yrs. 28 days vacation; all statutory holidays granted. 44-hr. wk. Superannuation. Sick leave benefits. Apply Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

Graduate Nurses for General Duty for 35-bed hospital. Salary: $155 per mo. plus $15 bonus. Maintenance, $35; live in nurses' home. After 1 yr., 1 mo. holiday with pay. 8-hr. shifts, 6-day wk. Apply Supt. of Nurses, General Hospital, Ladysmith, B.C.

Graduate Nurses (2) immediately for 40-bed hospital situated on new Hope-Princeton highway. 44-hr. wk. 28 days annual holiday plus 10 statutory holidays. Annual increases & accumulative sick leave. Self-contained nurses' home. Commencing salary: $1,800 annually plus $10 monthly bonus. Full maintenance for $25 per mo. For further particulars apply Director of Nursing, General Hospital, Princeton, B.C.

General Duty Nurses for General Hospital, Kenora, Ont. Apply to Supt. for particulars.

General Duty Nurses for Municipal Hospital, Brooks, Alta. Salary: $145 per mo. for 1st 6 mos. with increase to $150 per mo. after 6 mos. service, plus full maintenance & additional allowance for night duty. 8-hr. day, 6-day wk. 2 wks. holiday after 1 yr. service plus statutory holidays. Excellent nurses' home. On main line of C.P.R. & daily bus service to Medicine Hat & Calgary. Apply Supt. of Nurses.

General Duty Nurses for Day & Night Duty in small hospital. Good salary. Apply Supt., Rosamond Memorial Hospital, Almonte, Ont.

General Duty Nurses for small hospital in attractive Northern Ontario town. Salary: $140 per mo. plus full maintenance. Excellent living conditions. Also **Orderly** or **Male Nurse.** Salary according to qualifications. Apply Supt. of Nurses, Lady Minto Hospital, Cochrane, Ont.

General Duty Nurses for 350-bed Tuberculosis Hospital in centre of Laurentian summer & winter resort area, 2 hrs. from Montreal. Starting salary: $115 per mo. plus full maintenance. Attractive working hrs. with 1½ days off weekly & 1 week-end ea. mo. 1 mo. annual vacation. 14 days sick leave. Apply Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

• DIRECTOR OF NURSES •

WANTED

Applications are invited for the position of **Director of Nurses** for the **Royal Columbian Hospital, New Westminster, British Columbia.** Nearly completed addition to hospital brings total bed capacity to approx. 412. New Westminster, a thriving city, with a pop. of about 34,000 is located just 12 miles from Vancouver. Duties consist of directing Nursing Services & accredited School of Nursing with approx. 140 students. Teaching Degree & Administrative experience required. **Salary Range:** $4,200-4,800 per annum. Applicants must be Canadian citizens. Apply, giving in full details of age, education, training & experience, **Director, Royal Columbian Hospital, New Westminster, B.C.**

General Duty Nurses. 8-hr. broken day. 48-hr. wk. Gross salary: $163.40 monthly. All salaries have scheduled rate of increase. Cumulative sick leave. Pension plan in force. Blue Cross plan. 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital for Tuberculosis, Gravenhurst, Ont.

Asst. Supt. for 76-bed hospital. Apply, stating age, qualifications, experience & salary expected, Supt., Chipman Memorial Hospital, St. Stephen, N.B.

Graduate Nurse as X-Ray & Laboratory Technician immediately for modern 20-bed hospital. Salary: $160 & full maintenance. Apply Matron, Union Hospital, Leader, Sask.

General Duty Nurses (2) immediately for 15-bed hospital. Salary: $125 per mo. with full maintenance. Apply Sec.-Treas., Municipal Hospital, Magrath, Alta.

Nursing Arts Instructor, Science Instructor & Clinical Instructor for 220-bed hospital. Apply Supt. of Nurses, General Hospital, Brandon, Man.

Nursing Arts Instructor & Educational Director immediately. The hospital, located in capital city, is connected with large clinic & college which aids greatly in teaching students. Apply Director of Nurses, Evangelical Hospital, 6th & Thayer, Bismarck, North Dakota.

Registered Nurses for 250-bed approved hospital. 40-hr. wk. Salary: $200 base pay. Additional $20 for evening duty & $10 for nights. $5.00 increase every 6 mos. until $50. 1 mo. paid vacation per yr. Write Director, Nursing Service, St. Elizabeth Hospital, Yakima, Washington.

Asst. Night Supervisor for Toronto Hospital for the Treatment of Tuberculosis, Weston, Ont. Apply, stating experience & qualifications, to Director of Nursing Services.

Lady Supt. for the Restigouche & Bay Chaleur Soldiers' Memorial Hospital, Campbellton, New Brunswick. Duties to commence Jan. 1, 1950. Submit information re training & experience to A. B. Lumsden, Sec.-Treas., 9 Victoria St., Campbellton, N.B.

Correction

The author of the article "Nightingale Memorial Service," which appeared on the Private Duty Nursing Page in the October issue, was stated to be Sister Mary Grace. It should have been credited to F. Keleher, C.R.

WANTED

SUPERVISORS & HEAD NURSES FOR SURGICAL WARDS

for

Royal Columbian Hospital, New Westminster, B.C.

Gross Salaries: $195 and $185 respectively.

Registration in British Columbia essential.

8-hour day. 44-hour week. Day for all statutory holidays. 28 days' vacation after 1 year service. Apply to hospital.